PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Dichlorphenamide Preferred Specialty Management Policy
- Keveyis® (dichlorphenamide tablets – Strongbridge, generic)

REVIEW DATE: 05/10/2023

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Dichlorphenamide, a carbonic anhydrase inhibitor, is indicated for the treatment of **primary hyperkalemic periodic paralysis** (HyperPP), **primary hypokalemic periodic paralysis** (HypoPP), and related variants.[1] These conditions are heterogeneous and response to dichlorphenamide may vary; therefore, prescribers should evaluate the patient's response to dichlorphenamide after 2 months to decide whether it should be continued.

POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of the Preferred Product. For all medications (Preferred and Non-Preferred), the patient is required to meet the respective standard *Prior Authorization Policy* criteria. The program also directs the patient to try the Preferred Product prior to the approval of the Non-Preferred Product. Requests for the Non-Preferred Product will also be reviewed using the exception criteria (below). All approvals are provided for the duration listed in the Dichlorphenamide Prior Authorization Policy.

Documentation: Documentation is required for use of generic dichlorphenamide as noted in the criteria as **[documentation required]**. Documentation may include,

but is not limited to, chart notes, prescription claims records, prescription receipts, and/or other information.

Preferred Products: Dichlorphenamide
Non-Preferred Products: Keveyis

Dichlorphenamide non-preferred product(s) is(are) covered as medically necessary when the following non-preferred product exception criteria is(are) met. Any other exception is considered not medically necessary.

NON-PREFERRED PRODUCT EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Keveyis	**1.** Approve if the patient meets ALL of the following (A, B and C): **A)** Patient meets the standard *Dichlorphenamide Prior Authorization Policy* criteria; AND **B)** Patient has tried generic dichlorphenamide **[documentation required]**; AND **C)** Patient cannot continue to use generic dichlorphenamide tablets due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. **2.** For a patient who met criteria 1A but NOT 1B and 1C, approve the Preferred Product.

REFERENCES

1. Keveyis® tablets [prescribing information]. Trevose, PA: Strongbridge; November 2019.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	05/10/2023