Clinical Policy: Dichlorphenamide (Keveyis)

Reference Number: CP.PMN.261
Effective Date: 03.01.21
Last Review Date: 02.21 Revision Log
Line of Business: Commercial, HIM, Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Dichlorphenamide (Keveyis®) is an oral carbonic anhydrase inhibitor.

FDA Approved Indication(s)

Keveyis is indicated for the treatment of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Keveyis is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hyperkalemic/Hypokalemic Periodic Paralysis and Variants (must meet all)**:**

1. Diagnosis of primary hyperkalemic or hypokalemic periodic paralysis, or related variants (i.e., Andersen's syndrome, paramyotonia congenita);
2. Age ≥ 18 years;
3. Failure of acetazolamide at up to maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed 200 mg (4 tablets) per day.

Approval duration: 3 months

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Hyperkalemic/Hypokalemic Periodic Paralysis and Variants (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy as evidenced by reduced frequency of paralysis;
3. If request is for a dose increase, new dose does not exceed 200 mg (4 tablets) per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
acetazolamide (Diamox®)	250 to 1,000 mg/day PO in divided doses	1,000 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): hepatic insufficiency, severe pulmonary obstruction, hypersensitivity to dichlorphenamide or other sulfonamides, concomitant use of Keveyis and high dose aspirin
- Boxed warning(s): none reported

Appendix D: General Information
- Variants of periodic paralysis include paramyotonia congenita and Andersen syndrome.
- Per the Keveyis Prescribing Information: Primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants are a heterogeneous group of conditions, for which the response to Keveyis may vary. Therefore, prescribers should evaluate the patient's response to Keveyis after 2 months of treatment to decide whether Keveyis should be continued.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants	Initial dose of 50 mg PO QD or BID; titrate based on individual response at weekly intervals up to a maximum recommended daily dose of 200 mg	200 mg/day

VI. Product Availability

Tablet: 50 mg

VII. References

1. Keveyis Prescribing Information. Hawthorne, NY: Taro Pharmaceuticals U.S.A, Inc.; November 2019. Available at https://keveyis.com/keveyis-prescribing-information.pdf. Accessed on December 15, 2020.
2. Tawil R, McDermott MP, Brown R, et al. Randomized trials of dichlorphenamide in the periodic paralyses. Ann Neurol 2000;47:46-53.
3. Venance SL, Cannon SC, Fialho D, et al. The primary periodic paralyses: diagnosis, pathogenesis and treatment. Brain 2006; 129:8.
4. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed April 28, 2020.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created; adopted from CP.PCH.04 (policy to be retired); added Medicaid line of business; no significant changes.	12.15.20	02.21

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.