UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1177-10
Program	Prior Authorization/Notification
Medication	dichlorphenamide, Keveyis® (dichlorphenamide)*, Ormalvi™ (dichlorphenamide)*
P&T Approval Date	2/2016, 2/2017, 2/2018, 2/2019, 2/2020, 2/2021, 2/2022, 2/2023, 2/2024, 2/2025
Effective Date	5/1/2025

1. Background:

Keveyis® (dichlorphenamide)* is an oral carbonic anhydrase inhibitor indicated for the treatment of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants. Ormalvi™ (dichlorphenamide)* is an oral carbonic anhydrase inhibitor indicated for the treatment of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants.

Members will be required to meet the coverage criteria below.

2. Coverage Criteria[a]:

A. Initial Authorization

1. dichlorphenamide, **Keveyis***, or **Ormalvi*** will be approved based on **one** of the following criteria:

   a. Diagnosis of primary hyperkalemic periodic paralysis or related variant

   -OR-

   b. Diagnosis of primary hypokalemic periodic paralysis or related variant

Authorization of therapy will be issued for 12 months.

B. Reauthorization

1. dichlorphenamide, **Keveyis***, or **Ormalvi*** will be approved based on the following criterion:

   a. Documentation of positive clinical response

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

* Keveyis (brand) and Ormalvi are typically excluded from coverage. Tried/Failed criteria may be in place. Please refer to plan specifics to determine exclusion status.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Keveyis® [package insert]. Chicago, IL: Xeris Pharmaceuticals, Inc.; August 2024.
2. Ormalvi™ [package insert]. Cambridge, CB3 0FA, United Kingdom: Cycle Pharmaceuticals Ltd; February 2024.

Program	Prior Authorization/Notification – dichlorphenamide, Keveyis™ (dichlorphenamide), Ormalvi™
Change Control	
2/2016	New program.
2/2017	Annual review. No changes to coverage criteria.
2/2018	Annual review. No changes to coverage criteria.
2/2019	Annual review. Updated references. Updated background.
2/2020	Annual review. Updated references. No changes to coverage criteria.
2/2021	Annual review. No changes to coverage criteria.
2/2022	Annual review. No changes to coverage criteria.
2/2023	Annual review. Added state mandate with no changes to coverage criteria.
2/2024	Annual review. Updated reference.
2/2025	Updated initial authorization to 12 months. Added generic dichlorphenamide and Ormalvi. Added coverage exclusion statement for brand Keveyis and Ormalvi. Updated references.