

Keveyis (dichlorphenamide) Prior Authorization of Benefits (PAB) Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center 1-844-474-3341

1. Patient information		2. Physician information	
Name: _____		Prescribing physician: _____	
Patient ID #: _____		Address: _____	
DOB: _____		Phone: _____	
Date of Rx: _____		Fax: _____	
Phone: _____		Physician specialty: _____	
Email: _____		Physician DEA: _____	
		Physician NPI #: _____	
		Email: _____	
3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
Keveyis (dichlorphenamide)			Specify:
7. Diagnosis:			
8. Approval criteria: Check all boxes that apply.			
Note: Any areas not filled out are considered not applicable and may affect the outcome of this request.			
<input type="checkbox"/> Yes <input type="checkbox"/> No Patient has a diagnosis of primary periodic paralysis If Yes: <input type="checkbox"/> Yes <input type="checkbox"/> No Patient has had a diagnosis of primary periodic paralysis in the last 730 days <input type="checkbox"/> Yes <input type="checkbox"/> No Patient has had a claim for acetazolamide in the last 365 days <input type="checkbox"/> Yes <input type="checkbox"/> No Patient has had a claim for high dose aspirin in the last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No Patient has had a diagnosis of severe pulmonary disease in the last 365 days <input type="checkbox"/> Yes <input type="checkbox"/> No Patient has had a diagnosis of moderate to severe hepatic impairment in the last 365 days <input type="checkbox"/> Yes <input type="checkbox"/> No The requested dose is less than or equal to 4 units per day			
9. Physician signature			
_____		_____	
Prescriber or authorized signature		Date	
<p><i>Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.</i></p> <p>Note: Payment is subject to member eligibility. Authorization does not guarantee payment.</p>			
<p>The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.</p>			