



UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

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| Program Number    | 2026 P 1177-11   |
| Program           | Prior Authorization/Notification   |
| Medication        | dichlorphenamide, Keveyis <sup>®</sup> (dichlorphenamide)*, Ormalvi <sup>™</sup> (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, 2/2026               |
| Effective Date    | 5/1/2026   |

**1. Background:**

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

**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.**

<sup>a</sup> 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<sup>®</sup> [package insert]. Chicago, IL: Xeris Pharmaceuticals, Inc.; July 2025.
2. Ormalvi<sup>™</sup> [package insert]. Cambridge, CB3 0FA, United Kingdom: Cycle Pharmaceuticals Ltd; July 2025.

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| Program               | Prior Authorization/Notification – dichlorphenamide, Keveyis <sup>™</sup> (dichlorphenamide), Ormalvi <sup>™</sup>  |
| <b>Change Control</b> |   |
| 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. |
| 2/2026                | Annual review. Updated references.  |