Updated: 01/2025
DMMA Approved: 02/2025

Request for Prior Authorization for Palforzia (peanut allergen powder)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Palforzia (peanut allergen powder) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Prior Authorization Criteria:

Coverage may be provided with a diagnosis of **peanut allergy** and the following criteria is met:

- Member is 1 to 17 years of age during the initial dose escalation phase or at least 1 year of age for the up-dosing or maintenance phase of therapy.
- Must be prescribed by or in consultation with an allergist or immunologist
- Member must have all of the following:
  - Clinical history of allergy to peanuts or peanut-containing foods
  - Serum peanut-specific IgE level ≥0.35 kUA/L
  - Mean wheal diameter ≥3 mm larger than the negative control on skin-prick testing for peanut
- The prescriber attests that member has been counseled in regards to Palforzia and remaining on a peanut-avoidant diet.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- Must not have any of the following:
  - Uncontrolled asthma
  - History of eosinophilic esophagitis or other eosinophilic gastrointestinal disease
  - History of severe or life-threatening episode of anaphylaxis or anaphylactic shock in the past 2 months.
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
  - There must be clinical evidence indicating that member has experienced a significant improvement with treatment.
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK HEALTH OPTIONS

Updated: 01/2025
DMMA Approved: 02/2025

PALFORZIA (PEANUT ALLERGEN POWDER-DNFP) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

How was the diagnosis confirmed? Check all that apply:

- ☐ Clinical history of allergy to peanuts or peanut-containing foods
- ☐ Serum peanut-specific IgE level ≥ 0.35 kUA/L
- ☐ Mean wheal diameter ≥ 3 mm larger than the negative control on skin-prick testing

What dosing phase is the member currently in?

☐ Initial dose escalation phase ☐ Up-dosing or maintenance phase

Does the member have any of the following?

- ☐ Uncontrolled asthma
- ☐ History of eosinophilic esophagitis or other eosinophilic gastrointestinal disease
- ☐ History of severe or life-threatening episode of anaphylaxis or anaphylactic shock in the past 2 months

Has the member been counseled on Palforzia and the need to remain on a peanut-avoidant diet? ☐ Yes ☐ No

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date