

Prior Authorization Criteria
Palforzia (peanut allergen powder)

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.

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

- Member is 4 to 17 years of age during the initial dose escalation phase or at least 4 years of age for the up-dosing or maintenance phase of therapy.
- Must be prescribed by or in consultation with an allergist or immunologist.
- Must have a clinical history of allergy to peanuts or peanut-containing foods
- Member must have ONE of the following:
 - 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 diseases.
 - 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**
 - Documentation of 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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

**PALFORZIA (PEANUT ALLERGEN POWDER)
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 Wholecare Pharmacy Services. **FAX:** (888) 245-2049

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE:** (800) 392-1147 Mon – Fri 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Medication Initiated:

Billing Information

This medication will be billed: <input type="checkbox"/> at a pharmacy OR <input type="checkbox"/> medically, JCODE: _____	
Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's office <input type="checkbox"/> Member's home <input type="checkbox"/> Other	

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:
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Is there a history of allergy to peanuts or peanut-containing foods? Yes No

How was the diagnosis confirmed? Check all that apply:

- 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 an improvement with treatment? Yes No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature

Date

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