HIGHMARK WHOLECARE

Updated: 01/2025
PARP Approved: 03/2025

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 1 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.

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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? ☐ Yes ☐ No	Date Medication Initiated:	

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:

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