



Request for Prior Authorization
PEANUT (ARACHIS HYPOGAEA) ALLERGEN
POWDER-DNFP (PALFORZIA)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization (PA) is required for Peanut (Arachis hypogaea) Allergen Powder-dnfp (Palforzia). Payment will be considered under the following conditions:

- 1. Patient has a confirmed diagnosis of peanut allergy...
2. Patient is 4 to 17 years of age...
3. Prescribed by or in consultation with an allergist...
4. Patient has access to injectable epinephrine...
5. Will be used in conjunction with a peanut-avoidant diet...
6. Patient does not have any of the following:
a. Uncontrolled asthma; and/or
b. A history of eosinophilic esophagitis...
7. Patient will adhere to the complex up-dosing schedule...
8. The initial dose escalation...
9. Follows FDA approved dosing...
10. PA is required for all up-dosing dose levels...
11. Maintenance dosing will be considered...

Non-Preferred

Palforzia

**Request for Prior Authorization
PEANUT (*ARACHIS HYPOGAEA*) ALLERGEN
POWDER-DNFP (PALFORZIA)**

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Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis: _____

Attach documentation of a skin prick or peanut-specific serum IgE test.

Is prescriber an allergist or immunologist? Yes No (If no, note consultation with allergist or immunologist)

Consultation Date: _____

Physician Name, Phone & Specialty: _____

Does patient have access to injectable epinephrine? Yes No

Will Palforzia be used in conjunction with a peanut-avoidant diet? Yes No

Does patient have any of the following:

- Uncontrolled asthma Yes No
- A history of eosinophilic esophagitis or other eosinophilic gastrointestinal disease Yes No

Will patient adhere to the complex up-dosing schedule that requires frequent visits to the administering healthcare facility? Yes No

Provide date of dose escalation for the requested dose provided by a health care professional in a health care setting: _____ **Dose Level (1 through 11):** _____

For maintenance dosing, has patient successfully completed all dose levels of up-dosing? (attach documentation) Yes No

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*