Palforzia

Peanut (Arachis hypogaea) allergen powder-dnfp

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (ALL criteria must be met)

- ❑ Select the dosage request:
  - ❑ Initial Dose Escalation: 4 to 17 years of age.
  - ❑ Up-Dosing and Maintenance: 4 years of age and older.
- ❑ Medication prescribed by or in documented consultation with an allergy and immunology specialist.
- ❑ Confirmed **diagnosis of peanut allergy** documented in chart notes: Chart Note Page #: _____

Attestation:

- ❑ Member does NOT have any of the following:
  - Uncontrolled asthma or long-term use of systemic corticosteroid therapy for the treatment of asthma.
  - Diagnosis or symptoms of eosinophilic esophagitis or other eosinophilic gastrointestinal disease.
- ❑ Healthcare setting, prescriber, and dispensing pharmacy are certified in the Palforzia REMS program, and patient is enrolled in Palforzia REMS program.
- ❑ Prescriber has counseled patient to maintain a strict peanut-free diet while taking Palforzia.
- ❑ Patient must have active, unexpired injectable epinephrine, is instructed and trained on its appropriate use, and knows to seek immediate medical care upon its use.
- ❑ Patient will be observed during and after administration of the Initial Dose Escalation and the first dose of each Up-Dosing level, for at least 60 minutes.

Re-authorization Criteria:

Updated letter of medical necessity or updated chart notes demonstrating tolerance of the medication.

Initial Authorization: Up to six (6) months

Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date