SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Palforzia™ [Peanut (Arachis hypogaea) Allergen Powder-dnfp]

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Length of Authorization: 1 year

- ❑ Member must be 1 to 17 years of age

AND

- ❑ Member must have a documented clinical history of allergy to peanuts or peanut-containing foods

AND

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- ❑ Confirmed diagnosis of peanut allergy based on:
  - ❑ Serum immunoglobulin E (IgE) to peanut ≥ 14 kUA/L (kilos of allergen-specific units per liter) within the past 12 months; **OR**
  - ❑ Skin prick test (SPT) to peanut with a mean wheal diameter of ≥ 8 mm compared to control; **OR**
  - ❑ Clinical history of systemic reaction to peanut within the last 2 years with evidence of sensitization to peanut (serum IgE ≥ 0.35 and/or peanut SPT ≥ 3 mm); **OR**
  - ❑ Documented reaction to peanut upon supervised oral food challenge at a dose of ≤ 100 mg peanut protein (≤ 200 mg peanut flour)

AND

- ❑ Member has **NOT** received systemic corticosteroid therapy (oral, intramuscular, intravenous) for the treatment of asthma in any of the following manners:
  - ❑ Daily systemic corticosteroid for > 1 month during the past year; **OR**
  - ❑ More than 2 burst systemic corticosteroid courses in the past year with ≥ 1 week in duration; **OR**
  - ❑ Burst systemic corticosteroid course within 3 months prior to starting Palforzia™

AND

- ❑ Member has **NOT** been hospitalized for asthma within 1 year prior to starting Palforzia™

AND

- ❑ Member has **NOT** had emergency department (ED) visit for an asthma exacerbation within 6 months prior to starting Palforzia™

AND

- ❑ Member does **NOT** have a history of eosinophilic esophagitis, and/or other eosinophilic gastrointestinal diseases

AND

- ❑ Member does **NOT** have uncontrolled atopic dermatitis

AND

- ❑ Member does **NOT** have a medical condition that inhibits their ability to survive anaphylaxis, such as significantly reduced lung function, severe mast cell disorder, or cardiovascular disease

AND

- ❑ Member is **NOT** currently taking medications that can alter the effects of epinephrine (e.g., beta-blockers [oral], angiotensin-converting enzyme (ACE) inhibitor; angiotensin receptor blocker [ARB], calcium channel blocker [CCB], alpha-adrenergic blocker, ergot alkaloid)

AND

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- ❑ Member has **NOT** experienced severe anaphylaxis resulting in hypotensive shock, use of > 2 doses of epinephrine, and/or intubation within the prior 60 days

AND

- ❑ Palforzia™ is being requested by or in consultation with a specialist (Allergy and Immunology specialists)

AND

- ❑ Patient has been prescribed and/or has a refill history of epinephrine auto-injector

AND

- ❑ Prescriber attestation for the following:
  - ❑ Patient/caregiver understand how to use injectable epinephrine; **AND**
  - ❑ Patient/caregiver must be able to recognize the signs and symptoms of a serious allergic reaction and anaphylaxis; **AND**
  - ❑ Patient/caregiver understands the importance of continual daily dosing of Palforzia™ to sustain desensitization and will adhere to a daily dosing regimen, including maintenance phase, of Palforzia™ as prescribed; **AND**
  - ❑ Patient/caregiver will temporarily withhold Palfozia™ and contact the prescriber if the patient experiences an acute asthma exacerbation; **AND**
  - ❑ Patient/caregiver understands dose timing considerations (e.g., strenuous exercise, hot shower/bath); **AND**
  - ❑ Palfozia™ will be initiated at a REMS-certified healthcare facility; the initial dose escalation phase and the first dose of each of the 11 up-dosing phases will be given at a REMS-certified healthcare facility; **AND**
  - ❑ Patient/caregiver will adhere to the complex up-dosing schedule that requires frequent visits to the administering healthcare facility

Reauthorization Criteria: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member must continue to meet the above initial criteria

AND

- ❑ Member must continue to tolerate the prescribed daily doses of Palforzia™

AND

- ❑ Member has **NOT** experienced recurrent asthma exacerbations

AND

- ❑ Member has **NOT** experienced any treatment-restricting adverse effects (e.g., repeated systemic allergic reaction and/or severe anaphylaxis)

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Note: patients ≥ 18 years of age who met the initial approval criteria may continue maintenance treatment upon renewal

Medication being provided by a Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

REVISED/UPDATED/REFORMATTED: ~~6/18/2020; 11/9/2023;~~ **10/15/2024**