pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

PALFORZIA [peanut (*Arachis hypogaea*) allergen powder]

PRIOR AUTHORIZATION FORM *(form effective 01/05/2021)*

Prior authorization guidelines for **Palforzia** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug product(s) requested *(check all that apply to this request)*:

☐Palforzia Initial Dose Pack (0.5 to 6 mg) – package size = 13 capsules (5 doses per pack)
# of packs requested: _____ to last a total of _____ day(s) refills: _____

☐Palforzia 3 mg Pack (Level 1) – package size = 45 x 1 mg capsules (15 daily doses per pack)
# of packs requested: _____ to last a total of _____ days refills: _____

☐Palforzia 6 mg Pack (Level 2) – package size = 90 x 1 mg capsules (15 daily doses per pack)
# of packs requested: _____ to last a total of _____ days refills: _____

☐Palforzia 12 mg Pack (Level 3) – package size = 45 [30 x 1 mg capsules; 15 x 10 mg capsules) (15 daily doses per pack)
# of packs requested: _____ to last a total of _____ days refills: _____

☐Palforzia 20 mg Pack (Level 4) – package size = 15 x 20 mg capsules (15 daily doses per pack)
# of packs requested: _____ to last a total of _____ days refills: _____

☐Palforzia 40 mg Pack (Level 5) – package size = 30 x 20 mg capsules (15 daily doses per pack)
# of packs requested: _____ to last a total of _____ days refills: _____

☐Palforzia 80 mg Pack (Level 6) – package size = 60 x 20 mg capsules (15 daily doses per pack)
# of packs requested: _____ to last a total of _____ days refills: _____

☐Palforzia 120 mg Pack (Level 7) – package size = 30 [15 x 20 mg capsules; 15 x 100 mg capsules] (15 daily doses per pack)
# of packs requested: _____ to last a total of _____ days refills: _____

☐Palforzia 160 mg Pack (Level 8) – package size = 60 [45 x 20 mg capsules; 15 x 100 mg capsules] (15 daily doses per pack)
# of packs requested: _____ to last a total of _____ days refills: _____

☐Palforzia 200 mg Pack (Level 9) – package size = 30 x 200 mg capsules (15 daily doses per pack)
# of packs requested: _____ to last a total of _____ days refills: _____

☐Palforzia 240 mg Pack (Level 10) – package size = 60 [30 x 20 mg capsules; 30 x 100 mg capsules] (15 daily doses per pack)
# of packs requested: _____ to last a total of _____ days refills: _____

☐Palforzia 300 mg Pack (Level 11) – package size = 15 x 300 mg sachets (15 daily doses per pack)
# of packs requested: _____ to last a total of _____ days refills: _____

☐Palforzia 300 mg Maintenance Pack – package size = 30 x 300 mg sachets (30 daily doses per pack)
# of packs requested: _____ to last a total of _____ days refills: _____

Diagnosis *(submit documentation)*:	Dx code (*required*):

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Is the medication being prescribed by a specialist, such as an allergist/immunologist?	☐Yes ☐No
Does the beneficiary have either of the following contraindications to Palforzia? *Check all that apply.* ☐Uncontrolled asthma ☐A history of eosinophilic esophagitis or other eosinophilic gastrointestinal disease	☐Yes ☐No *Submit documentation.*
Has the beneficiary received instruction to use Palforzia in conjunction with a peanut-avoidant diet?	☐Yes ☐No *Submit documentation.*
Has the beneficiary received or been prescribed injectable epinephrine?	☐Yes ☐No *Submit documentation.*
INITIAL requests	
Does the beneficiary have a clinical history of allergy to peanuts or peanut-containing foods?	☐Yes ☐No *Submit documentation.*
Do any of the following apply to the beneficiary? *Check all that apply.* ☐Positive skin prick test (SPT) to peanut ≥3 mm compared to control ☐Positive serum immunoglobulin E (IgE) test to peanut >0.35 KU_A/L ☐Ara h 2 sIgE >0.35 KU_A/L ☐Positive medically supervised oral food challenge	☐Yes ☐No *Submit documentation.*
RENEWAL requests	
Was the beneficiary able to tolerate Palforzia doses up to and including the 3 mg dose during initial dose escalation?	☐Yes ☐No *Submit documentation.*
Did the beneficiary experience recurrent asthma exacerbations or persistent loss of asthma control?	☐Yes ☐No *Submit documentation.*
Did the beneficiary experience any allergic reactions, including gastrointestinal reactions, that were severe, recurrent, bothersome or lasted longer than 90 minutes since starting Palforzia?	☐Yes ☐No *Submit documentation.*
Did the beneficiary experience severe or persistent gastrointestinal symptoms suggestive of eosinophilic esophagitis since starting Palforzia, such as dysphagia, vomiting, nausea, gastroesophageal reflux, chest pain, or abdominal pain?	☐Yes ☐No *Submit documentation.*
Is the patient able to adhere to the daily dosing requirements?	☐Yes ☐No *Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: