IOWA Health and Human Services

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

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
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. **Request adheres to all FDA approved labeling for requested drug and indications, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2. **Patient has a confirmed diagnosis of peanut allergy, as documented by a skin prick test to peanut ≥ 3 mm compared to control or a peanut-specific serum IgE ≥ 0.35 kUA/L (kilos of allergen-specific units per liter); and**
3. **Patient is 1 to 17 years of age at initiation of therapy or 1 year of age and older for continued up-dosing and maintenance therapy; and**
4. **Prescribed by or in consultation with an allergist or immunologist; and**
5. **Patient has access to injectable epinephrine: and**
6. **Will be used in conjunction with a peanut-avoidant diet; and**
7. **The initial dose escalation and the first dose of each new up-dosing level is administered under the supervision of a health care professional in a health care setting with the ability to manage potentially severe allergic reactions, including anaphylaxis. Initial dose escalation and the first dose of all up-dosing levels is not to be billed to the Iowa Medicaid outpatient pharmacy program as the initial dose escalation is administered in the provider office and should be billed via the medical benefit and the first dose of all up-doing is provided via the Office Dose Kit; and**
8. **PA is required for all up-dosing dose levels (dose level 1 through 11); and**
9. **Maintenance dosing will be considered with documentation patient has successfully completed all dose levels of up-dosing.**

Non-Preferred

☐ Palforzia

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: _____

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Does patient have access to injectable epinephrine? ☐ Yes ☐ No

Will Palforzia be used in conjunction with a peanut-avoidant diet? ☐ 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

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 Health and Human Services, that the member continues to be eligible for Medicaid.*