



Service Authorization (SA) Form

Anti-Allergens, Oral – Palforzia™ peanut (*Arachis hypogaea*) allergen powder-dnfp

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth:

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number:

Fax Number:

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

DIAGNOSIS AND MEDICAL INFORMATION

For initial approval, complete the following questions to receive a 6-month approval:

1. Is Palforzia™ being requested by or in consultation with an allergy or immunology specialist?

☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION (CONTINUED)

2. Is the member between 1 and 17 years of age? **AND**
☐ Yes ☐ No
3. Does the member have a clinical history of allergy to peanuts or peanut-containing foods? **AND**
☐ Yes ☐ No
4. Does the physician verify that they have reviewed the member's history and that the member is a candidate for Palforzia™ treatment following the REM requirements? **AND**
☐ Yes ☐ No
5. Will Palforzia™ be initiated at a REMS-certified healthcare facility and will 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?
☐ Yes ☐ No

For renewal, complete the following questions to receive a 1-year approval:

6. Does the member continue to meet the above criteria? **AND**
☐ Yes ☐ No
7. Will the member continue to tolerate the prescribed daily doses of Palforzia™? **AND**
☐ Yes ☐ No
8. Can you confirm that the member has **not** experienced recurrent asthma exacerbations? **AND**
☐ Yes ☐ No
9. Can you confirm that the member has **not** experienced any treatment-restricting adverse effects (e.g., repeated systemic allergic reaction and/or severe anaphylaxis)?
☐ Yes ☐ No

Note: Members 18 years of age or older who met the initial approval criteria may continue maintenance treatment upon renewal

Prescriber Signature (Required)

Date

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826