PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Palforzia - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Palforzia - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Palforzia (peanut [A hypogaea] allergen powder)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy? Y N

[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]

[If no, then skip to question 4.]

2. Is the patient having a beneficial response to treatment, evidenced by increased tolerance of peanut protein with possibly only mild allergic symptoms? Y N _____

[Note: Documentation must be submitted.]

	[If no, then no further questions.]		
3.	Has the patient been prescribed injectable epinephrine?	Y N	
	[Note: Documentation must be submitted.]		
	[No further questions.]		
4.	Is the requested drug being prescribed for any of the following: A) Emergency treatment of allergic reactions, including anaphylaxis, B) Concurrent use with a monoclonal antibody agent?	Y N	
	[If yes, then no further questions.]		
5.	Does the patient have any of the following: A) Uncontrolled, or severe Asthma, B) History of eosinophilic esophagitis or other eosinophilic gastrointestinal disease, C) History of cardiovascular disease, including uncontrolled or inadequately controlled hypertension, D) History of a mast cell disorder, including mastocytosis, urticarial pigmentosa, and hereditary or idiopathic angioedema?	Y N	
	[If yes, then no further questions.]		
6.	Is this request for initiation of therapy?	Y N	
	[If no, then skip to question 8.]		
7.	Is the patient between 4 and 17 years of age?	Y N	
	[If yes, then skip to question 10.]		
	[If no, then no further questions.]		
8.	Is this request for up-dosing or maintenance therapy?	Y N	
	[If no, then no further questions.]		
9.	Is the patient 4 years of age or older?	Y N	
	[If no, then no further questions.]		
10.	Has documentation been submitted confirming diagnosis of peanut allergy, including both of the following: A) Serum immunoglobulin E (IgE) level response to peanut showing greater than or equal to 0.35 kUA/L (kilos of allergen-specific units per liter), B) Skin-prick test with peanut showing a mean wheal diameter that is at least 3mm larger than the negative control?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
11.	Does the patient have a clinical history of allergic reaction to peanut, evidenced by previous signs and symptoms of systemic reaction after peanut or peanut-containing food ingestion (hives, swelling, wheezing, gastrointestinal disturbances) that necessitated the need for injectable epinephrine prescription?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		

12. Will the patient be on a peanut-avoidant diet?	Y N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
13. Has the patient been prescribed injectable epinephrine and has the patient or caregiver been educated on appropriate use?	Y N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
14. Is the requested drug being prescribed by or in consultation with an allergist or immunologist?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date