Prior Authorization Request Form for
peanut (arachis hypogaea) allergen powder-dnfp **(Palforzia)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the requested medication prescribed by an allergist or immunologist, or in consultation with an allergist or immunologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Has the provider satisfied the requirements of the REMS program?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the patient between the ages of 4 to 17 years?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a documented history of peanut allergy?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a history of diagnostic evidence of peanut allergy, including either serum IgE to peanut of greater than or equal to 0.35 kUA/L (serum testing) and/or positive skin prick test (SPT) for peanut greater than or equal to 3 mm greater than negative control?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have uncontrolled asthma, eosinophilic esophagitis or other eosinophilic gastrointestinal diseases?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **7**
7. Has the patient had a severe or life-threatening anaphylaxis within the previous 60 days prior to starting therapy?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **8**

Prior Authorization Request Form for
peanut (arachis hypogaea) allergen powder-dnfp **(Palforzia)**

8. Does the provider acknowledge that the patient will be counseled on all of the following: 1) avoiding peanut ingestion; 2) the need for access to an epinephrine injector; and 3) Palforzia is not intended to treat emergencies?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge.
Please sign and date:

_____ _____
Prescriber Signature Date

[05 August 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: