CareSource

PHARMACY POLICY STATEMENT **Ohio Medicaid**	
DRUG NAME	Palforzia [Peanut (*Arachis hypogaea*) Allergen Powder-dnfp]
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Office, Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 1 dose pack (30 sachets) per 30 days after loading doses (see Dosage Allowed)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Palforzia (Peanut (*Arachis hypogaea*) Allergen Powder) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

PEANUT ALLERGY

For **initial** authorization:

1. Member is between 4 and 17 years of age; AND
2. Medication is prescribed and managed by an allergist; AND
3. Documentation must be submitted to confirm presence of peanut allergy, as evidenced by serum IgE >0.35kUa/L OR Skin Prick Test wheal >3mm compared to control; AND
4. Chart notes must show the member does **not** have any of the following:
   a) Anaphylaxis in the last 60 days;
   b) Uncontrolled asthma;
   c) Eosinophilic esophagitis or other eosinophilic gastrointestinal disease;
   d) Cardiovascular disease or uncontrolled hypertension; AND
5. Member has been assessed for ability to comply with daily dosing requirement, and can adhere to the daily dosing schedule; AND
6. Member understands to continue a peanut-avoidant diet.
7. **Dosage allowed:** One initial dose escalation packet (13 caps) for 1 day. One up-dosing packet (pack size varies) for 15 days each x 11 packets (165 days total). Then, maintenance dose of one 300mg sachet once daily.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. If the member is over 17 years of age, therapy must have been initiated between 4-17 years of age; AND
2. Chart notes must show the member has **not** had worsening of asthma or emergence of eosinophilic gastrointestinal disease; AND
3. Chart notes must show the member tolerates therapy and has **not** had anaphylaxis requiring a higher level of care; AND
4. Member must be compliant with daily dosing regimen.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Palforzia (Peanut (*Arachis hypogaea*) Allergen Powder) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/15/2020	New policy for Palforzia created.

References:

1. Palforzia [package insert]. Brisbane, CA; Aimmune Therapeutics, Inc.: February, 2020.
2. PALISADE Group of Clinical Investigators, et al. AR101 oral immunotherapy for peanut allergy. *N Engl J Med*. 2018;379(21):1991-2001. doi: 10.1056/NEJMoa1812856.
3. Chu DK, Wood RA, French S, et al. Oral immunotherapy for peanut allergy (PACE): A systematic review and meta-analysis of efficacy and safety.
4. Patrawala, M., Shih, J., Lee, G. and Vickery, B., 2020. Peanut Oral Immunotherapy: a Current Perspective. Current Allergy and Asthma Reports, 20(5).

Effective date: 10/20/2020
Revised date: 05/15/2020