Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Prior Authorization (PA) Form

Palforzia™ peanut (*Arachis hypogaea*) allergen powder-dnfp

If the following information is not complete, correct, or legible, the PA process can be delayed.
Please use one form per member.

MEMBER INFORMATION

Last Name: **First Name:**

Medicaid ID Number: **Date of Birth:** __ – __ – __

Gender: ☐ **Male** ☐ **Female** **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. **Palforzia™** is being requested by/ in consultation with a specialist (Allergy and Immunology specialists?

   ☐ Yes ☐ No

(Form continued on next page.)

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AVAPEC-2553-20 May 2020

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

2. Is the member is between 4 to 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. Physican verifies that they have reviewed the members history and they are a candidate for **Palforzia™** treatment following the REM requirements: **AND**
   ☐ Yes verified ☐ No not verified

5. Palforzia™ will be initiated at a REMS-certified healthcare facility; 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. Member must continue to tolerate the prescribed daily doses of Palforzia; AND
   ☐ Yes ☐ No
8. Member has not experienced recurrent asthma exacerbations; AND
   ☐ Yes ☐ No
9. Member has not have experienced any treatment-restricting adverse effects (e.g., repeated systemic allergic reaction and/or severe anaphylaxis)
   ☐ Yes ☐ No

*Note: Members ≥ 18 years of age 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 PA process.
Submission of documentation does NOT guarantee coverage.

The completed form may be: **FAXED 1-844-512-7020**.