AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

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

Fax back to: 1-855-799-2553

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. 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 4 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 physican 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 PA process.
Submission of documentation does NOT guarantee coverage.