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CardinalCare
Virginia's Medicaid Program

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

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

oIf the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

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 1 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 SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Prime Therapeutics Management LLC/Attn: GV – 4201
P.O. Box 64811, St. Paul, MN 55164-0811