



Montana Healthcare Programs  
Drug Prior Authorization Coverage Criteria

Palforzia™ (arachis hypogaea)

**Review Criteria**

Member must meet all the following criteria:

- **Initial Approval:**
  - Prescribed by or in consultation with an allergist/immunologist
  - Member is 4 to 17 years of age (**applies to initiation of therapy only**)
    - If member is older than 17 years of age, and was established on the therapy between the age of 4 to 17, approval will continue
  - Member has a confirmed clinical history of systemic allergic reaction to peanuts
  - Documentation provided that shows a positive skin prick test (wheal diameter  $\geq$  3mm) OR peanut specific IgE ( $\geq$  0.35kUA/L)
  - Medication is used in conjunction with a peanut-avoidance diet
  - Initial approval x 6 months
- **Continuation Renewals:**
  - Must be adherent to therapy
  - Approval limits:
    - If member has been titrated to the maintenance dose of 300mg, approve for 1 year.
    - If member has not been titrated to 300mg, but is still titrating with the lower doses, approve for 6 months and request update after that time.