US Family Health Plan
Prior Authorization Request Form for
Peanut (arachis hypogaea) allergen powder-dnfp (Palforzia)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Clinical documentation may be required for review.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #:		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the requested medication prescribed by an allergist or immunologist, or in consultation with an allergist or immunologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Has the provider satisfied the requirements of the REMS program?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the patient between the ages of 4 to 17 years?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a documented history of peanut allergy?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a history of diagnostic evidence of peanut allergy, including either serum IgE to peanut of greater than or equal to 0.35 kUA/L (serum testing) and/or positive skin prick test (SPT) for peanut greater than or equal to 3 mm greater than negative control?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have uncontrolled asthma, eosinophilic esophagitis or other eosinophilic gastrointestinal diseases?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **7**

7. Has the patient had a severe or life-threatening anaphylaxis within the previous 60 days prior to starting therapy?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **8**
8. Does the provider acknowledge that the patient will be counseled on all of the following: 1) avoiding peanut ingestion; 2) the need for access to an epinephrine injector; and 3) Palforzia is not intended to treat emergencies?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge.
Please sign and date:

_____ _____
Prescriber Signature Date

[05 August 2020]