



# TEXAS MEDICAID Clinical Edit Prior Authorization peanut allergen powder (PALFORZIA)

## STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING

Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

## STEP 2: CLINICAL PRIOR AUTHORIZATION CRITERIA

Indicate Primary Diagnosis: \_\_\_\_\_ ICD 10 Code: \_\_\_\_\_

1. Is the client greater than or equal to ( $\geq$ ) 4 years of age?

Yes (Go to #2)

No (Deny)

2. Does the client have at least one (1) paid claim for the requested agent in the last 60 days?

Yes (Go to #5)

No, and the client is 4-17 years of age (Go to #3)

No, and the client is greater than or equal to ( $\geq$ ) 18 years of age (Deny)

3. Does the client have a diagnosis of peanut allergy in the last 730 days?

Yes (Go to #4)

No (Deny)

4. Is the medication being prescribed by, or in conjunction with, an Allergist or Immunologist?  
[Manual Step]

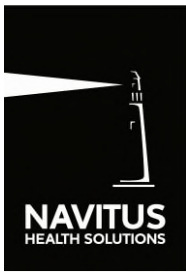
Yes (Go to #5)

No (Deny)

5. Does the client have one (1) claim for auto-injectable epinephrine in the last 365 days or is the patient receiving auto-injectable epinephrine concurrently?

Yes (Go to #6)

No (Deny)



6. Does the client have a history of severe, unstable or uncontrolled asthma **OR** a history of eosinophilic esophagitis in the last 365 days?

Yes (Deny)

No (Approve – 365 days)

**STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If criteria not met, submit chart documentation with form citing complex medical circumstances.  
For questions, please call Navitus Customer Care at 1-877-908-6023.