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 (≥) 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 (≥) 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.