Pharmacy Drug Policy Checklist

POLICY NAME	Palforzia (peanut allergen powder)	POLICY #	2793P

Criteria

Exclusion Criteria – Any of the following prevents coverage

- ☐ **2.1** Uncontrolled asthma
- ☐ **2.2** Eosinophilic esophagitis and other eosinophilic gastrointestinal disease

Coverage Criteria

- ☐ **1.1** Documented peanut allergy confirmed with an IgE ≥ 0.35 KUA/L or skin-prick test ≥ 3 mm compared to control
- ☐ **1.2** Age 1 year through 17 years at the beginning of treatment
- ☐ **1.3** Prescribed by an immunologist (immune system doctor) or allergist (allergy doctor)
- ☐ **1.4** Documentation to support that Palforzia will be used in addition to an injectable epinephrine product and a peanut-avoidant diet