



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Palforzia

Page: 1 of 2

Effective Date: 8/30/2024

Last Review Date: 7/2024

Applies to:	<input checked="" type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input checked="" type="checkbox"/> Florida Kids
	<input checked="" type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input checked="" type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Pennsylvania	<input type="checkbox"/> Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Palforzia under the patient's prescription drug benefit.

Description:

Palforzia is an oral immunotherapy indicated for the mitigation of allergic reactions, including anaphylaxis, that may occur with accidental exposure to peanut. Palforzia is approved for use in patients with a confirmed diagnosis of peanut allergy. Initial Dose Escalation may be administered to patients aged 4 through 17 years. Up-Dosing and Maintenance may be continued in patients 4 years of age and older.

Palforzia is to be used in conjunction with a peanut-avoidant diet.

Applicable Drug List:

Palforzia

Policy/Guideline:

The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for the mitigation of allergic reactions, including anaphylaxis, in a patient with a confirmed diagnosis of peanut allergy
AND
- The diagnosis of peanut allergy has been confirmed by a serum IgE or skin-prick test
AND
- The requested drug is being used in conjunction with a peanut-avoidant diet
AND
- The requested drug is being prescribed by, or in consultation with, an allergist or immunologist
[Note: The Initial Dose Escalation and first dose of each Up-Dosing level must only be administered in a healthcare setting equipped to monitor patients, and to identify and manage anaphylaxis.]
AND
- The patient does not have uncontrolled asthma OR a history of eosinophilic esophagitis or other eosinophilic gastrointestinal disease
AND



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- The patient is 4 to 17 years of age OR the request is for Up-dosing or Maintenance phase of treatment in a patient 4 years of age or older

Approval Duration and Quantity Restrictions:

Approval: 12 months

Quantity Level Limit: Reference Formulary for drug specific quantity level limits

References:

1. Palforzia [package insert]. Brisbane, CA: Aimmune Therapeutics, Inc.; March 2023.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2023. <https://online.lexi.com>. Accessed January 02, 2024.
3. Micromedex (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: <https://www.micromedexsolutions.com/> (cited: 01/02/2024).
4. Palisade Group of Clinical Investigators. AR101 Oral Immunotherapy for Peanut Allergy. *N Engl J Med* 2018; 379:1991-2001.