

Clinical Policy Title:	peanut Allergen Powder-dnfp
Policy Number:	RxA.866
Drug(s) Applied:	Palforzia
Original Policy Date:	10/18/2024
Last Review Date:	12/11/2025
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Peanut Allergy (must meet all):

1. Diagnosis of peanut allergy;
2. Will be used in combination with a peanut avoidant diet.

Approval Duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. Peanut Allergy (must meet all):

1. Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria.

Approval Duration

All Lines of Business (except Medicare): 12 months

References

1. Palforzia. Prescribing Information. Brisbane, CA: Aimmune Therapeutics, Inc. March 2023. Available at: <https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=17f5be03-6705-4ac9-b8f3-bc4993ebc0eb&type=display#section-14>. Accessed October 18, 2024.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy was established	10/18/2024	12/05/2024
Policy was reviewed.	12/11/2025	12/11/2025

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.