Clinical Policy: Peanut Allergen Powder-dnfp (Palforzia)
Reference Number: CP.PMN.220
Effective Date: 03.01.20
Last Review Date: 02.20
Line of Business: Commercial, HIM, Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Peanut, *Arachis hypogaea*, allergen powder-dnfp (Palforzia™) is an oral immunotherapy.

FDA Approved Indication(s)
Palforzia is 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.

Limitation(s) of use: Palforzia is not indicated for the emergency treatment of allergic reactions, including anaphylaxis.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Palforzia is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Peanut Allergy (must meet all):
      1. Diagnosis of peanut allergy;
      2. Prescribed by an allergist or immunologist;
      3. Age ≥ 4 years and ≤ 17 years;
      4. Confirmation of positive skin test or peanut-specific serum IgE;
      5. Palforzia is prescribed concurrently with injectable epinephrine;
      6. Medical justification supports necessity for oral immunotherapy in addition to peanut avoidance (e.g., member has had previous history of severe reactions to peanuts, member has a severe peanut allergy that can be triggered by smell);
      7. Dose does not exceed 300 mg per day.
      Approval duration: 6 months

   B. Other diagnoses/indications
      1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is
II. Continued Therapy
A. Peanut Allergy (must meet all):
   1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   2. If the member has required usage of injectable epinephrine that exceeds the health plan quantity limit, medical justification supports continued therapy with Palforzia;
   3. Age ≤ 17 years;
   4. If request is for a dose increase, new dose does not exceed 300 mg per day.
   Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):
   1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
   2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:
A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information
Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
ICER: Institute for Clinical and Economic Review
REMS: Risk Evaluation Mitigation Strategy

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): uncontrolled asthma, history of eosinophilic esophagitis or other eosinophilic gastrointestinal disease
- Boxed warning(s): anaphylaxis; Palforzia has a Risk Evaluation Mitigation Strategy (REMS) program with the following requirements:
  o Health care providers who prescribe Palforzia must be certified with the program by enrolling.
  o Health care settings must be certified in the program, have on-site access to equipment and personnel trained to manage anaphylaxis, and establish policies and
procedures to verify that patients are monitored during and after the Initial Dose Escalation and first dose of each Up-Dosing level.

- Patients must be enrolled in the program prior to initiation of Palforzia treatment and must be informed of the need to have injectable epinephrine available for immediate use at all times, the need for monitoring with the Initial Dose Escalation and first dose of each Up-Dosing level, the need for continued dietary peanut avoidance, and how to recognize the signs and symptoms of anaphylaxis.
- Pharmacies must be certified with the program and must only dispense Palforzia to health care settings that are certified or to patients who are enrolled depending on the treatment phase.

Appendix D: General Information
- In the pivotal study for approval, there was no significant difference between Palforzia and placebo in adult patients (treatment difference 27.2% [95% CI: -1.7, 56]; p = 0.064). The study evaluated the proportion of patients able to tolerate 600 mg of peanut protein with no more than mild symptoms at the end of the trial, with success being demonstrated if the lower bound of the 95% CI was greater than 15%.
- In an evidence report published July 2019, the Institute for Clinical and Economic Review (ICER) states that there is moderate certainty of a comparable, small, or substantial net health benefit and a small (but non-zero) likelihood of a negative net health benefit for Palforzia compared with strict avoidance and rapid use of epinephrine (P/I, promising, but inconclusive). This is because the significant response rate observed with Palforzia comes with an increase in adverse effects.

V. Dosage and Administration

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<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
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<tbody>
<tr>
<td>Peanut allergy</td>
<td>- Initial dose escalation: 0.5 to 6 mg PO over 1 day</td>
<td>300 mg/day</td>
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<td>- Up-dosing: 3 mg PO with up-dosing every 2 weeks as tolerated until the maintenance dose is reached (refer to prescribing information for details)</td>
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<td>- Maintenance dose: 300 mg PO daily</td>
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The initial dose escalation and first dose of each new level in the up-dosing schedule must be administered under supervision of a healthcare professional with the ability to manage severe allergic reactions, including anaphylaxis.

VI. Product Availability
- Pull-apart capsules: 0.5 mg, 1 mg, 10 mg, 20 mg, 100 mg
- Sachets: 300 mg

VII. References

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>Policy created</td>
<td>11.26.19</td>
<td>02.20</td>
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<tr>
<td>Modified prescriber restriction to indicate that Palforzia must be prescribed by an allergist or immunologist (removed “or in consultation with”) due to significant safety concerns for anaphylaxis and requirements for up-dosing to be administered under supervision of a healthcare professional.</td>
<td>02.11.20</td>
<td>02.20 (ad-hoc)</td>
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**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or
regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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