



## Glutamine (Endari) Prior Authorization

Drug Applied:	glutamine
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### Criteria:

Drug Applied will be approved when the requested medication is being used for an FDA approved indication and all of the following criteria are met:

#### I. Initial Therapy Criteria

##### A. **Sickle cell disease** as indicated by chart notes within past 180 days

1. Patient is using the requested agent to reduce the acute complications of sickle cell disease **and**
2. Patient is 5 years of age or older **and**
3. Patient will be using requested agent with concurrent hydroxyurea therapy or chart notes document serious adverse effects to hydroxyurea **and**
4. Patient has been stabilized on hydroxyurea for at least 3 months with maximally tolerated dose **and**
5. Patient has had 2 or more painful sickle cell crises within the past 12 months **and**
6. Chart notes and/or prescriber do not provide documentation that patient will be using the requested agent in combination with Adakveo (crizanlizumab-tmca) or Oxbryta (voxelotor) for the requested indication **and**
7. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., hematology)

**Approval Duration:** 12 months

#### II. Continued Therapy Criteria

##### A. **Sickle cell disease** as indicated by chart notes within past 12 months

1. Patient meets the initial therapy criteria above **and**
2. Documented clinical benefit since starting the requested agent (i.e., reduction in acute complications of sickle cell disease) **and**
3. Chart notes and/or prescriber do not provide documentation that patient will be using the requested agent in combination with Adakveo (crizanlizumab-tmca) or Oxbryta (voxelotor) for the requested indication

**Approval Duration:** 12 months

**Policy Owned by:** Curative PBM team