SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: L-glutamine (Endari™) oral powder

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ❑ Member must be 5 years of age or older
- ❑ Provider must submit member's current weight: _____
- ❑ Provider must prescribe according to FDA approved weight-based dosing. Member will be dosed as follows **(check prescribed dose; doses above maximum recommended for weight will NOT be approved)**:
  - ❑ <30 kg: 5 g (1 packet) twice daily **(total dose 10 g/day)**
  - ❑ 30 to 65 kg: 10 g (2 packets) twice daily **(total dose 20 g/day)**
  - ❑ >65 kg: 15 g (3 packets) twice daily **(total dose 30 g/day)**
- ❑ Member must have a diagnosis of sickle cell disease

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- ❑ Provider must be a hematologist or oncologist specializing in treatment of sickle cell disease
- ❑ Member must have been compliant with hydroxyurea for the last 90 days **(compliance will be verified by pharmacy paid claims)**
- ❑ Member has experienced at least 2 documented sickle cell crises (SCC) events within the preceding 12 months **(submit documentation)**
- ❑ Medical chart notes from the last 12 months must be submitted for documentation of frequency of SCC events and emergency department or other medical facility visits due to SCC events
- ❑ Member will **NOT** take L-glutamine (Endari™) concomitantly with Adakveo® (crizanlizumab) infusions, or any experimental treatment for sickle cell disease complications

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ All initial authorization criteria continues to be met
- ❑ Member must be compliant with **BOTH** L-glutamine (Endari™) **AND** hydroxyurea **(compliance will be verified by pharmacy paid claims)**
- ❑ Member must meet **ONE** of the following:
  - ❑ Frequency of the member's sickle cell crisis events must have decreased since last approval of L-glutamine (Endari™) **(submit documentation)**
  - ❑ Frequency of the member's sickle cell crisis events have been maintained below the number of events at baseline **(medical chart notes must be submitted to document frequency of SCC events and emergency department or other medical facility visits due to SCC events since last approval of L-glutamine [Endari™])**

Medication being provided by a Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****