UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2018 P 2135-2
Program	Prior Authorization/Medical Necessity
Medications	Endari (L-glutamine Powder for Solution)
P&T Approval Date	11/2017, 2/2018
Effective Date	5/1/2018; Oxford only: 5/1/2018

1. Background:

Endari (L-glutamine powder for solution) is indicated to reduce the acute complications of sickle cell disease in adult and pediatric patients 5 years of age and older. The recommended dose is 5 to 15 grams orally twice daily based on body weight.

2. Coverage Criteria:

A. Endari

1. **Initial Authorization**
   a. **Endari** will be approved based on the following criteria:

      1) **Both** of the following:
         a) Diagnosis of sickle cell disease
         b) Used to reduce acute complications of sickle cell disease

      - AND –

      2) **One** of the following:
         a) Patient is using Endari with concurrent hydroxyurea therapy
         b) Patient is unable to take hydroxyurea due to a contraindication or intolerance

      - AND –

      3) Patient has had 2 or more painful sickle cell crises within the past 12 months

      - AND –

      4) History of failure to non-prescription *L*-glutamine supplementation.

      Authorization will be issued for 12 months.

2. **Reauthorization**

   1. **Endari** will be approved based on the following criterion:

a. Documentation of positive clinical response to Endari therapy

Authorization will be issued for 12 months.

3. Additional Clinical Programs:

- Supply Limits may be in place

4. References:

1. Endari prescribing information. Emmaus Medical, Inc. Torrance, CA. July 2017.

Program	Prior Authorization/Medical Necessity – L-glutamine Powder
Change Control	
11/2017	New program.
2/2018	Added requirement for *L*-glutamine supplementation.