Prior Authorization Criteria

MISSISSIPPI DIVISION OF MEDICAID

L-glutamine powder for solution (Endari®) PA CRITERIA:

FDA approved indication:
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.

Initial Authorization: 12 months

Prior authorization requests for Endari may be approved if the following criteria are met:

☐ Yes ☐ No Patient is within the age range as recommended by the FDA label; ***AND***

☐ Yes ☐ No Is prescribed by or in consultation with a hematologist physician who specializes in treatment of Sickle Cell Disease;

AND

Both of the following

☐ Yes ☐ No Diagnosis of Sickle Cell Disease; ***AND***
☐ Yes ☐ No Used to prevent the acute complications of sickle cell disease

AND

One of the following:

☐ Yes ☐ No Hydroxyurea is otherwise contraindicated or not tolerated*

OR

☐ Yes ☐ No *Endari is being prescribed with concurrent hydroxyurea therapy due to lack of effectiveness as demonstrated by a suboptimal response after receiving maximum tolerated dose of hydroxyurea and documented compliance (as reflected in paid pharmacy claims) over the past 6 months;*

AND

☐ Yes ☐ No Patient has had 2 or more painful sickle cell crises within the past 12 months.

Reauthorization: 12 months

☐ Yes ☐ No Currently receiving Endari and hydroxyurea concomitantly unless documented contraindication/intolerance; ***AND***
☐ Yes ☐ No Patient is responding positively to therapy; AND
☐ Yes ☐ No If request is for a dose increase, the new dose does not exceed 30 grams per day based on weight.

Dosing: Recommended dose is 5 to 15 grams orally twice daily based on body weight.

Product Availability: Carton of 60 packets (5gm/packet)