UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Endari

Program	Prior Authorization
Medication	L-glutamine powder for solution (Endari)
Issue Date	11/2017
Pharmacy and Therapeutics Approval Date	11/2017
Effective Date	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

Authorization will be issued for 12 months.

2. Reauthorization

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

1) Documentation of positive clinical response to Endari therapy

Authorization will be issued for 12 months.

3. References:

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

Program	Prior Authorization – Endari (L-glutamine powder for solution)
Change Control	
11/2017	New program.