

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:

<p>A. <u>Endari</u></p> <p>1. <u>Initial Authorization</u></p> <p>a. Endari will be approved based on the following criteria:</p> <p>1) <u>Both</u> of the following:</p> <p style="margin-left: 40px;">a) Diagnosis of sickle cell disease b) Used to reduce acute complications of sickle cell disease</p> <p style="text-align: center;">- AND -</p> <p>2) <u>One</u> of the following:</p> <p style="margin-left: 40px;">a) Patient is using Endari with concurrent hydroxyurea therapy b) Patient is unable to take hydroxyurea due to a contraindication or intolerance</p> <p style="text-align: center;">- AND -</p> <p>3) Patient has had 2 or more painful sickle cell crises within the past 12 months</p> <p>Authorization will be issued for 12 months.</p> <p>2. <u>Reauthorization</u></p>
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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.