L-glutamine products; Endari, L-glutamine

Endari (L-glutamine)

Coverage Criteria:
Reserved for members that meet all of the following criteria:

1. Diagnosis of Sickle Cell Disease; and,
2. Patient is ≥ 5 years old; and,
3. Tried over the counter L-glutamine and failed due to a documented allergic reaction; and,
4. Patient has experienced two or more painful crises within the previous 12 months despite continuous use of hydroxyurea (unless contraindicated); and,
5. Prescribed within FDA approved dose.

Prescriber Restriction:
None

Renewal Criteria:
Renewals will be provided annually when originally authorized by HealthPartners, and prescribed within FDA approved doses, and medication has provided a positive impact. For Sickle Cell Disease, positive impact is defined as a reduced frequency of painful crises.

Coverage Duration:
Initial and re-authorizations will be for 12 months.

Other Criteria:
None

L-glutamine

Coverage Criteria:

Reserved for members that meet all of the following criteria:

1. Diagnosis of Sickle Cell Disease; and,
2. Patient is ≥ 5 years old; and,
3. Patient has experienced two or more painful crises within the previous 12 months despite continuous use of hydroxyurea (unless contraindicated); and,
4. Prescribed within FDA approved dose of 5-15 grams twice daily.

Prescriber Restriction:

None

Renewal Criteria:

Renewals will be provided when originally authorized by HealthPartners, and prescribed within FDA approved doses, and medication has provided a positive impact. For Sickle Cell Disease, positive impact is defined as a reduced frequency of painful crises.

Coverage Duration:

Initial authorization will be provided for one year.
Re-authorizations will be for 3 years.

Other Criteria:

None

P&T Date: November 2018
Effective Date: 1/1/19