AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Endari™ (L-glutamine oral powder)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Approval – 6 months

- ❑ Member must be 5 years of age or older. Please note member's current weight: _____

AND

- ❑ Member will be dosed as follows **(dose above maximum recommended for weight will not be approved)**:
  - ❑ <30 kg: 5 g (1 packet) twice daily **(total dose 10 g/day)**
  - ❑ 30 to 65 kg: 10 g (2 packets) twice daily **(total dose 20 g/day)**
  - ❑ >65 kg: 15 g (3 packets) twice daily **(total dose 30 g/day)**
- ❑ Member must have a diagnosis of sickle cell disease

(Continued on next page)

AND

- ❑ Provider must be a hematologist or oncologist specializing in treatment of sickle cell disease

AND

- ❑ Member must have been compliant with hydroxyurea for the last 90 days **(compliance will be verified by pharmacy paid claims)**

AND

- ❑ Member has experienced at least 2 documented sickle cell crises (SCC) events within the preceding 12 months

AND

- ❑ Medical chart notes from the last 12 months must be submitted for documentation of frequency of SCC events and emergency department or other medical facility visits due to SCC events

AND

- ❑ Member will not take Endari™ concomitantly with Oxbryta® (voxelotor) tablets, Adakveo® (crizanlizumab) infusions, or any experimental treatment for sickle cell disease complications

Continuation of Therapy Approval – 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ All of the initial authorization criteria for Endari continues to be met

AND

- ❑ Patient must have been compliant with **BOTH** Endari™ **AND** hydroxyurea since last approval **(monthly pharmacy claims must be noted)**

AND

- ❑ The frequency of the member's sickle cell crisis events must have decreased since last approval of Endari™ **OR** have been maintained below the number of events at baseline **(medical chart notes must be submitted to document frequency of SCC events and emergency department or other medical facility visits due to SCC events since last approval of Endari™)**

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: ~~11/16/2018; 3/21/2019;~~ 3/192020
REVISED/UPDATED: ~~2/22/2018; 5/10/2019;6/11/2020;~~ **10/27/2023**