PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☐ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Endari® (L-glutamine)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Prescriber is: ☐ Hematologist ☐ Other: please list _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Endari 5 g powder packet

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dose and frequency: _____
Patient weight: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be 5 years of age and older, AND
2. Endari must be prescribed by hematology, AND
3. Patient must have documented diagnosis of sickle cell disease, AND
4. Request is for FDA approved dose, AND
5. Patient has had 2 or more crises in the last 12 months, AND
6. Patient has had at least 80% adherence to the maximum tolerated dose of hydroxyurea for the past 180 days or justification provided regarding intolerance or contraindication to the use of hydroxyurea.

For continuation, patient must have met the following requirements every 6 months:

1. Patient has had a reduction in the number of sickle cell crises, AND
2. Patient continues on an FDA approved dose of Endari.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 05/2018
Last reviewed 05/2020

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Sickle cell disease
☐ *Other – the patient's condition is:* _____
Rationale for use: _____

B. Please verify dose requested matches FDA labeled dose (provide patient weight above).

C. Please provide clinical documentation (chart notes) showing number of crises in the past 12 months.

D. Has patient been adherent to the maximum tolerated dose of hydroxyurea for the past 180 days?

☐ Yes

☐ No, *rationale*: _____

Request to continue a previously authorized approval

Priority Health Precertification Documentation

A. Please provide clinical documentation of a reduction in the number of sickle cell crises since starting Endari.

B. Please provide updated patient weight and verify requested dose matches FDA label.

Additional information

Note: Requires reauthorization every 6 months and documentation that patient continues to meet continuation criteria.

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