Prior Authorization Request Form for
L-glutamine oral powder **(Endari)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient GREATER THAN or EQUAL TO 5 years of age?	☐ Yes **Proceed to question 2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of sickle cell anemia or Sickle beta-thalassemia?	☐ Yes **Proceed to question 3**	☐ No **STOP** **Coverage not approved**
3. Has the patient had GREATER THAN or EQUAL TO 2 sickle cell crises in the last 12 months?	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**
4. Has the patient had an inadequate treatment response to a 3 month trial of BOTH hydroxyurea AND blood transfusion therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[14 February 2018]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: