HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
L-GLUTAMINE

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ L-glutamine

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of sickle cell disease (SCD)?	☐	☐	**Please provide documentation**
2. Is the prescribing provider a physician who specializes in SCD (e.g. hematologist)?	☐	☐	
3. Has the member tried hydroxyurea for at least 3 months unless the member has a contraindication?	☐	☐	**Please provide documentation**
4. Will L-glutamine be used in combination with hydroxyurea, unless contraindicated or intolerant?	☐	☐	
5. Have preventative measures been discussed with the member including regular clinic visits, healthy diet and folic acid supplements, adequate hydration, avoiding extreme temperatures, and smoking cessation?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member had a positive response shown by an improvement in the incidence of VOC from baseline?	☐	☐	**Please provide documentation**
3. Has the member been consistently taking hydroxyurea, unless contraindicated or intolerant?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-CHIP-161
Origination Date: 05/13/2020
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024