REALRx

Healthy U
Health Choice Utah

# PRIOR AUTHORIZATION REQUEST FORM
## L-GLUTAMINE

**For authorization, please answer each question and fax this form PLUS chart notes back to the RealRx Medicaid 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 Pharmacy Customer Service for assistance.

- Healthy U Medicaid: 855-856-5694
- Health Choice Utah: 855-864-1404

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: | Diagnosis 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: | |
| **PRESCRIBER CERTIFICATION** | |
| **I hereby certify this treatment is indicated, necessary and meets the guidelines for use.** | |
| **Physician's Signature:** | **Date:** |

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

Policy PHARM-MM-161
Origination Date: 05/13/2020
Reviewed/Revised Date: 06/10/2026
Next Review Date: 06/10/2027
Current Effective Date: 07/01/2026

**Confidentiality Notice**

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.