



**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **ENDARI (GLUTAMINE)**. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: <http://www.providers.kaiserpermanente.org/mas/formulary.html>

**1 – Patient Information**

Patient Name: \_\_\_\_\_ Kaiser Medical ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**2 – Prescriber Information**

Is the prescriber a hematology-oncology specialist?  No  Yes

If consulted with a specialist, specialist name and specialty: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ NPI: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_

Prescriber Phone #: \_\_\_\_\_ Prescriber Fax #: \_\_\_\_\_

**3 – Pharmacy Information**

Pharmacy Name: \_\_\_\_\_ Pharmacy NPI: \_\_\_\_\_

Pharmacy Phone # \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: \_\_\_\_\_

Sig: \_\_\_\_\_

Drug 2: Name/Strength/Formulation: \_\_\_\_\_

Sig: \_\_\_\_\_

### 5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?  
 Initial therapy                       Continuing therapy, State date: \_\_\_\_\_
2. Indicate the Member’s diagnosis for the requested medication: \_\_\_\_\_
3. Does member have documented diagnosis of sickle cell anemia or sickle beta-thalassemia? **AND**  
 No  Yes
4. Member is ≥5 years of age? **AND**  
 No  Yes
5. Is member currently taking hydroxyurea, unless contraindication or intolerance, **AND** one of the following:
  - a. ≥2 sickle cell pain crises within prior 12 months requiring intervention (e.g., home-managed, hospitalizations, emergency department, or urgent care visits), OR
  - b. History of acute chest syndrome (documented by pulmonary infiltrate on chest x-ray films) No  Yes

**For Continuation of Therapy, Please Respond to Additional Questions Below:**

1. Is Member nonadherent to follow-up assessment or medication itself, **AND**  
 No  Yes
2. Is there a reduction in frequency of sickle cell pain crises and/or acute chest syndrome events?  
 No  Yes

### 6 – Prescriber Sign-Off

**Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. Provide any additional supporting information that should be taken into consideration:**

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**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

**Prescriber Signature:**

**Date:**

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