

<b>Clinical Policy Title:</b>	I-glutamine
<b>Policy Number:</b>	RxA.366
<b>Drug(s) Applied:</b>	glutamine
<b>Original Policy Date:</b>	03/06/2020
<b>Last Review Date:</b>	12/11/2025
<b>Line of Business Policy Applies to:</b>	All lines of business (except Medicare)

## Criteria

### I. Initial Approval Criteria

#### A. Sickle Cell Disease (must meet all):

1. Diagnosis of sickle cell disease;
2. Trail and failure of hydroxyurea unless contraindicated or clinically significant adverse effects are experienced.

#### Approval duration

**All Lines of Business (except Medicare):** 12 months

### II. Continued Therapy Approval

#### A. Sickle Cell Disease (must meet all):

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

#### Approval duration

**All Lines of Business (except Medicare):** 12 months

## References

1. Yawn BP, Buchanan GR, Afenyi-Annan AN, et al. Management of sickle cell disease: summary of the 2014 evidence-based report by expert panel members. JAMA 2014;312(10):1033-48. Available at: <https://pubmed.ncbi.nlm.nih.gov/25203083/>. Accessed August 28, 2024.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established	01/2020	03/06/2020
Policy was reviewed: 1. Policy title table was updated. 2. Continued Therapy Approval Criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance...". 3. References were updated.	07/12/2020	09/14/2020
Policy was reviewed: 1. Continued Therapy Approval	05/31/2021	09/14/2021

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

<p>Criteria II.A.1 was rephrased to “Member is currently receiving medication that has been authorized by RxAdvance...”</p> <p>2. References were reviewed and updated.</p>		
<p>Policy was reviewed:</p> <p>1. References were reviewed and updated.</p>	03/22/2022	07/18/2022
<p>Policy was reviewed:</p> <p>1. References were reviewed and updated.</p>	04/17/2023	07/13/2023
<p>Policy was reviewed.</p>	10/19/2023	10/19/2023
<p>Policy was reviewed:</p> <p>1. Removed age restrictions.</p> <p>2. Removed dose restrictions.</p> <p>3. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days.</p> <p>4. Removed reauthorization requirement for positive response to therapy.</p> <p>5. Updated approval duration verbiage.</p> <p>6. References were reviewed and updated.</p>	08/28/2024	09/13/2024
<p>Policy was reviewed.</p>	12/05/2024	N/A
<p>Policy was reviewed.</p>	12/11/2025	12/11/2025