



PRIOR AUTHORIZATION POLICY

POLICY: Sickle Cell Disease – L-glutamine Prior Authorization Policy

- Endari® (L-glutamine oral powder – Emmaus Medical, generic)

REVIEW DATE: 01/28/2026

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

L-glutamine oral powder, an amino acid, is indicated to **reduce the acute complications of sickle cell disease** in patients ≥ 5 years of age.¹

L-glutamine is an essential amino acid and serves as a precursor of nucleic acids and nucleotides including the pyridine nucleotides (nicotinamide adenine dinucleotide and reduced nicotinamide adenine dinucleotide).^{1,2} These pyridine nucleotides play key roles in the regulation and prevention of oxidative damage in red blood cells and studies have shown that oxidative phenomena may play a significant role in the pathophysiology of sickle cell disease.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of L-glutamine oral powder. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with

L-glutamine oral powder as well as the monitoring required for adverse events and long-term efficacy, approval requires L-glutamine oral powder to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Documentation: Documentation is required for use of L-glutamine oral powder as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information.

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is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. **Sickle Cell Disease [documentation required]**. Approve for 1 year if the patient meets BOTH of the following (A and B):
 - A) Patient is \geq 5 years of age; AND
 - B) The medication is prescribed by or in consultation with a physician who specializes in sickle cell disease (e.g., a hematologist).

CONDITIONS NOT COVERED

- **Endari® (L-glutamine oral powder – Emmaus Medical, generic)**

is(are) considered not medically necessary for ANY other use(s).

REFERENCES

1. Endari™ oral powder [prescribing information]. Torrance CA: Emmaus Medical; June 2025.
2. Brandow AM, Carroll CP, Creary S, et al. American Society of Hematology 2020 guidelines for sickle cell disease: management of acute and chronic pain. *Blood Adv.* 2020;4:2656-2701.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	01/03/2024
Selected Revision	Generic L-glutamine oral powder was added to the policy. Policy name was changed from Sickle Cell Disease – Endari PA to Sickle Cell Disease – L-glutamine PA.	08/28/2024
Annual Revision	No criteria changes.	01/15/2025
Annual Revision	No criteria changes.	01/28/2026

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