Commercial/Healthcare Exchange PA Criteria

Effective: May 2017

Prior Authorization: Gluten Intolerance Policy

Products Affected: Drug products containing gluten

Policy Description:
This policy establishes ConnectiCare's criteria for requested coverage of a compounded medication due to a Gluten Intolerance/Celiac disease.

Note: The most likely source of gluten contamination will come from starch. It is highly unlikely that any excipient other than starch will contain any measurable amount of gluten.

Exclusion Criteria: N/A

Required Medical Information:

1. Diagnosis
2. Previous medications tried/failed

Age Restrictions: N/A

Prescriber Restrictions: N/A

Coverage Duration: 12 months

Other Criteria:

A. Patient has Celiac Disease, diagnosed by both of the following:
   a. Positive serological finding (i.e. a positive tissue transglutaminase result); **AND**
   b. Abnormal duodenal biopsy; **AND**
B. Patient has had an adequate trial of TWO (2) commercially available gluten-free preparations covered on the formulary; **OR**
C. There are no gluten-free formulations commercially available agent(s) covered on the formulary.

References:

1. Talley NJ, Walker MM. Celiac Disease and Nonceliac Gluten or Wheat Sensitivity. JAMA Internal Medicine. 2017.

Policy Revision history

Rev #	Type of Change	Summary of Change	Sections Affected	Date
1	New Policy	New Policy	All	05/2017
2	Update	Moved to updated template P&T Review History: 5/17, 1/18	All	02/05/2020