

## 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