

PRIOR AUTHORIZATION REQUEST FORM
SAVELLA®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: Savella® (milnacipran)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Has the member been diagnosed with fibromyalgia with a widespread pain for > 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member had a 3 month trial and failure or contraindication to each of the following: <ul style="list-style-type: none"> • pregabalin • Tricyclic antidepressants (i.e. amitriptyline) • duloxetine 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

REAUTHORIZATION

1. Is the requesting for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does clinical documentation show continued medical necessity and that the member has responded to treatment?	<input type="checkbox"/>	<input type="checkbox"/>	

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

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Additional information:

Physician Signature:

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Policy PHARM- 067
Origination Date: 08/15/2019
Reviewed/Revised Date: 01/22/2020
Next Review Date: 01/23/2021
Current Effective Date: 01/23/2020

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