PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Savella - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Savella - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Savella (milnacipran)

Quantity   Frequency   Strength

Route of Administration   Expected Length of Therapy

Patient Information

Patient Name: ______________________

Patient ID: ______________________

Patient Group No.: ______________________

Patient DOB: ______________________

Patient Phone:

Prescribing Physician

Physician Name: ______________________

Physician Phone: ______________________

Physician Fax: ______________________

Physician Address: ______________________

City, State, Zip: ______________________

Diagnosis: ______________________ **ICD Code:** ______________________

Comments: ______________________

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy? Y N

[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]

[If no, then skip to question 3.]

2. Is there documentation showing the patient has had a beneficial response to treatment? Y N

[Note: Documentation must be provided.]

[No further questions.]

3. Is the patient 18 years of age or older?	Y N
[If no, then no further questions.]	
4. Does the patient have clinically diagnosed fibromyalgia?	Y N
[Note: Documentation must be provided.]	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date