Prior Authorization Request Form for Savella (milnacipran)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is Savella being used for a diagnosis of fibromyalgia?	☐ Yes Proceed to 2	☐ No **STOP** **Coverage not approved**
2. The preferred agents are: 1) venlafaxine [Effexor, Effexor XR]**; 2) gabapentin** [Neurontin]**; 3) TCAs** [**tricyclic antidepressants**: amitriptyline (Elavil), desipramine (Norpramin), doxepin (Sinequan), imipramine (Tofranil), nortriptyline (Pamelor), protriptyline (Vivactil)]; and, **4) cyclobenzaprine.**	**Proceed to question 3**	
3. Are ALL of the preferred agents listed above contraindicated in this patient?	☐ Yes **Sign and date below**	☐ No Proceed to question 4
4. Has the patient previously responded to Savella and changing to a preferred agent would incur unacceptable risk?	☐ Yes **Sign and date below**	☐ No Proceed to question 5
5. Has the patient tried one of the preferred agents and experienced adverse effects?	☐Yes Document agent(s) in **7**	☐ No Proceed to question 6
6. Has the patient had an adequate therapeutic trial with one of the preferred agents and the use resulted in therapeutic failure?	☐ Yes Document agent(s) in **7**	☐No **Coverage not approved**
7. DOCUMENT the Step 1 agents(s) that has been tried, then sign and date below:		

Prior Authorization Request Form for Savella (milnacipran)

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[18 April 2012]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: