US Family Health Plan
Prior Authorization Request Form for
Savella **(milnacipran)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

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:		

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

_____ _____
Prescriber Signature Date

[18 April 2012]