CAREFIRST - DC EXCHANGE 5T
Savella Step Therapy (HMF)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Savella Step Therapy (HMF).

Patient Information

Patient Name:

Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐

Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (select from list of drugs shown)

Savella (milnacipran)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1.	Is the requested drug being prescribed for the treatment of fibromyalgia?	**Y** ☐	**N** ☐
2.	Is the patient 18 years of age or older?	**Y** ☐	**N** ☐
3.	Is the request for continuation of therapy?	**Y** ☐	**N** ☐
4.	Has the patient achieved or maintained a positive clinical response to the requested drug (e.g., improvement in pain)?	**Y** ☐	**N** ☐
5.	Has the patient experienced an inadequate treatment response to duloxetine?	**Y** ☐	**N** ☐
6.	Has the patient experienced an intolerance to duloxetine?	**Y** ☐	**N** ☐
7.	Does the patient have a contraindication that would prohibit a trial of duloxetine?	**Y** ☐	**N** ☐

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