PRIOR AUTHORIZATION CRITERIA

DRUG CLASS	**PAIN MANAGEMENT**
BRAND NAME (generic)	**SAVELLA (milnacipran)**

Status: CVS Caremark® Criteria
Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS
Savella is indicated for the management of fibromyalgia.
Savella is not approved for use in pediatric patients.

COVERAGE CRITERIA
The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for the management of fibromyalgia

AND

- The patient is 18 years of age or older

  AND

  - The request is NOT for continuation of therapy

  OR

  - The request is for continuation of therapy

    AND

    - The patient has achieved or maintained a positive clinical response to the requested drug (e.g., improvement in pain)

Duration of Approval (DOA):

- 1345-A: Initial therapy DOA: 6 months; Continuation of therapy DOA: 12 months

REFERENCES

1. Savella [package insert]. Madison, NJ: Allergan USA, Inc; December 2022.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2023. https://online.lexi.com. Accessed April 24, 2023.Micromedex (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 04/24/2023).