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CONTAINS CONFIDENTIAL PATIENT INFORMATION

Savella (mlnacipran)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
Savella (mlnacipran)	_____	_____	Specify: _____

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

Initial Therapy:

☐ Yes ☐ No Patient has a diagnosis of fibromyalgia

☐ Yes ☐ No Patient has had a trial and therapy failure at a therapeutic dose with gabapentin plus one of the following preferred generic agents: tricyclic antidepressant or SNRI WITH documented non-pharmacologic therapies (cognitive behavior therapies, exercise, etc.)

☐ Yes ☐ No Patient is currently taking opioids **If Yes:**

☐ Yes ☐ No A plan to decrease and/or discontinue the opioid(s) is provided*

Continued Therapy:

☐ Yes ☐ No There has been a significant decrease in opioid use or discontinuation of opioid(s) after the initial three (3) month authorization (documentation* must be provided)

*Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

9. PHYSICIAN SIGNATURE

_____ _____

Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.