OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process may be delayed.**

Drug Requested: Savella® (milnacipran HCL)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member has tried and failed 30 days of therapy with **TWO** of the following generic medications:
  - ❑ duloxetine (Cymbalta®) 20, 30 or 60 mg capsules
  - ❑ gabapentin (Neurontin®) immediate release capsules
  - ❑ lidocaine (Lidoderm®) 5% topical patches
  - ❑ pregabalin (Lyrica®) immediate release capsules

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 11/19/2009
REVISED/UPDATED: 6/8/2011; 9/7/2011; 11/29/2014; 4/17/2015; 5/22/2015; 12/29/2015; 12/19/2016; 8/17/2017; (Reformatted) 6/21/2019; 4/25/2022; 6/4/2022; **6/17/2022**