Mountain Pacific
INNOVATING BETTER HEALTH
Mailing Address: P.O. Box 5119 | Helena, MT 59604
Phone: 406.443.6002 | Toll-free: 1.800.395.7961
Fax: 406.513.1928 | Toll-free: 1.800.294.1350

Montana Healthcare Programs Prior Authorization Request Form for Use of Savella® (milnacipran)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

1. Member is 18 years of age or older: ☐ Yes ☐ No
2. Member has a diagnosis of fibromyalgia: ☐ Yes ☐ No
3. If medication is nonpreferred (please refer to the Montana Medicaid Preferred Drug List for current preferred options), member has had an inadequate response, contraindication or intolerance to a preferred therapy: ☐ Yes ☐ No ☐ N/A – Drug is preferred.

   Drug name: _____ **Date used:** _____

   Reason for discontinuation: _____
4. Provider attests they have reviewed the black box warning for suicidality: ☐ Yes ☐ No
5. Provider attests they will use with caution in combination with other serotonergic agents to avoid serotonin syndrome: ☐ Yes ☐ No

Limitations:
Maximum daily dose: 200mg daily

Initial authorization will be issued for 1 year.

☐ CONTINUATION OF THERAPY

1. Provider attests they have reviewed the black box warning for suicidality: ☐ Yes ☐ No
2. Provider attests they will use with caution in combination with other serotonergic agents to avoid serotonin syndrome: ☐ Yes ☐ No

Limitations:
Maximum daily dose: 200mg daily

Reauthorization will be issued for 1 year.

Please complete form, including required attachments, and fax to:
Drug Prior Authorization Unit at 1-800-294-1350