Pharmacy Prior Authorization

MERCY CARE (MEDICAID)

Savella (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Mercy Care at **1-800-854-7614**.
When conditions are met, we will authorize the coverage of Savella (Medicaid).

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Savella (milnacipran)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis:_____ **ICD Code:**_____

Circle the appropriate answer for each question.

1. Does the patient have a diagnosis of fibromyalgia or juvenile fibromyalgia? Y N

   [If no, then no further questions.]

2. Has the patient failed a 2 month trial of a formulary agent (e.g., duloxetine, cyclobenzaprine, amitriptyline, nortriptyline, gabapentin, tramadol)? Y N

   If yes, please document drug(s) tried and reason for failure:

   _____

   [If no, then no further questions.]

3. Is the patient 13 years of age or older? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**