

Policy Name:	Savella (milnacipran)	Policy #:	1562P
---------------------	------------------------------	------------------	--------------

Purpose of the Policy

The purpose of this policy is to establish the criteria for the coverage of Savella.

Statement of the Policy

Health Alliance Medical Plans and Health Alliance Northwest will approve the use of Savella (milnacipran) when the following criteria have been met.

Criteria

1. Coverage Criteria

- 1.1 Documented diagnosis of fibromyalgia
- 1.2 Documented failure after at least 3 months, intolerance, or contraindication to at least one tricyclic antidepressant (e.g., amitriptyline, nortriptyline)
- 1.3 Documented failure after at least 3 months, intolerance, or contraindication to at least one muscle relaxant (e.g., cyclobenzaprine, methocarbamol, metaxalone)
- 1.4 Documented failure after at least 3 months, intolerance, or contraindication to gabapentin or pregabalin
- 1.5 Documented failure after at least 3 months, intolerance, or contraindication to duloxetine
- 1.6 Documented non-pharmacologic therapy (e.g., exercise, cognitive behavioral therapy)

2. Approval Period

- 2.1 12 months

CPT Codes

--	--

HCPCS Codes

--	--

References

1. Goldenberg, D. L. , Burckhardt, C. & Crofford, L. (2004). Management of Fibromyalgia Syndrome. JAMA: The Journal of the American Medical Association, 292 (19), 2388-2395.
2. Lee YH, Song GG. Comparative efficacy and tolerability of duloxetine, pregabalin, and milnacipran for the treatment of fibromyalgia: a Bayesian network meta-analysis of randomized controlled trials. Rheumatol Int. 2016 May;36(5):663-72.
3. Macfarlane GJ, Kronisch C, Dean LE, et al. EULAR revised recommendations for the management of fibromyalgia. Ann Rheum Dis 2017;76:318–328.
4. Savella (milnacipran HCl) oral tablets [prescribing information]. Allergan Pharmaceuticals USA, Inc,

Irvine, CA; December 2022.

Created Date: 11/17/05

Effective Date: 11/17/05

Posted to Website: 01/01/2022

Revision Date: 08/03/2023

DISCLAIMER

This Medical Policy has been developed as a guide for determining medical necessity. The process of medical necessity review also entails review of the most recent literature and physician review. Medical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care. Health Alliance encourages input from providers when developing and implementing medical policies. Benefit determinations are based on applicable contract language in the member's Policy/ Subscription Certificate/ Summary Plan Description. This Medical Policy does not guarantee coverage. There may be a delay between the revision of this policy and the posting on the web. Please contact the Health Alliance Customer Service Department at 1-800-851-3379 for verification of coverage.