Clinical Policy: Milnacipran (Savella)
Reference Number: CP.PPA.15
Effective Date: 08/12
Last Review Date: 05/17
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Milnacipran (Savella®) is a selective serotonin and norepinephrine reuptake inhibitor (SNRI).

FDA approved indication
Savella is indicated for the management of fibromyalgia.

Policy/Criteria
Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of health plans affiliated with Centene Corporation® that Savella is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Fibromyalgia (must meet all)**:**

1. Diagnosis of fibromyalgia;
2. Age ≥ 18 years;
3. Member meets one of the following (a or b):
   a. Failure of a 30 day trial of duloxetine at up to maximally indicated doses in the last 180 days, unless contraindicated or clinically significant adverse effects are experienced;
   b. Contraindication or intolerance to duloxetine and failure of a 30 day trial of amitriptyline or cyclobenzaprine at up to maximally indicated doses in the last 180 days, unless both agents are contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed 200 mg/day (2 tablets/day).

Approval duration: 12 months

B. Other diagnoses/indications

1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Fibromyalgia (must meet all)**:**

1. Currently receiving medication via Centene health benefit or member has previously met initial approval criteria;
2. Documentation of positive response to therapy;

3. If request is for a dose increase, new dose does not exceed 200 mg/day (2 tablets/day).

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy; or
2. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

Approval duration: 12 months

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents;

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
SNRI: selective serotonin and norepinephrine reuptake inhibitor

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Fibromyalgia	Based on efficacy and tolerability, dosing may be titrated according to the following schedule: *Day 1:* 12.5 mg once *Days 2-3*: 25 mg/day (12.5 mg twice daily) *Days 4-7:* 50 mg/day (25 mg twice daily) *After Day 7:* 100 mg/day (50 mg twice daily) Recommended dose is 100 mg/day (50 mg twice daily)	200 mg/day (100 mg twice daily)

VI. Product Availability

Tablets: 12.5 mg, 25 mg, 50 mg, 100 mg

VII. Workflow Document

CP.PPA.15.milnacipran (Savella) workflow

VIII. References

1. Savella Prescribing Information. Irvine, CA: Allergan USA, Inc.; December 2016. Available at: https://www.savella.com/. Accessed January 12, 2017.
2. Clauw DJ. Fibromyalgia: a clinical review. JAMA. 2014; 311(15): 1547-1555.
3. Häuser W, Walitt B, Fitzcharles M-A, Sommer C. Review of pharmacological therapies in fibromyalgia syndrome. *Arthritis Research & Therapy*. 2014;16(1):201. doi:10.1186/ar4441.
4. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2017. Available at: http://www.clinicalpharmacology-ip.com/.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Updated criteria for trial and failure of medications prior to approval	08/14	08/14
Criteria modified to require use of first line trials for ≥ 30 days within the previous 6 months	08/15	08/15
Updated references to reflect current literature search Updated criteria for trial and failure to include cyclobenzaprine to criteria if contraindication to amitriptyline. Added appropriate screening of drug to drug interaction of MAOI therapy due to absolute contraindication with Savella therapy Updated Renewal Criteria to include member currently receiving medication through this health plan. Added max dose (200mg/day) to initial criteria #E and renewal criteria #B.	02/16	05/16
-Modified criteria to allow trial and failure of either amitriptyline or cyclobenzaprine (instead of requiring trial of amitriptyline first prior to cyclobenzaprine) if duloxetine is contraindicated due to lack of evidence that one is better than the other -Converted to new template -Modified age restriction from ≥ 17 years to ≥ 18 years-per PI, use of Savella is not recommended in pediatric population below the age of 18 -Removed safety requirement related to "no concomitant use of monoamine oxidase inhibitors (MAOI) therapy OR history of MAOI therapy within the past 14 days" per template update -Added documentation of positive response to therapy for re-auth	03/17	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
-Updated references		

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers,

members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.