

TRICARE Pharmacy Program Medical Necessity Form for Savella (milnacipran)



5616

This form applies to the TRICARE Pharmacy Program (TPharm). The medical necessity criteria outlined on this form also apply at Military Treatment Facilities (MTFs). The form must be completed and signed by the prescriber.

- Formulary medications on the DoD Uniform Formulary that are medically accepted for treatment of fibromyalgia include the tricyclic antidepressants (e.g. amitriptyline) and cyclobenzaprine (Flexeril). **Savella (milnacipran) is non-formulary, but available to most beneficiaries at the non-formulary cost share.**
- The purpose of this form is to provide information that will be used to determine if the use of Savella instead of a formulary medication is medically necessary. If Savella is determined to be medically necessary, non-Active duty beneficiaries may obtain it at the formulary cost share.
- TRICARE will not cover Savella for Active duty service members unless it is determined to be medically necessary instead of a formulary medication, in which case it will be available to Active duty service members at no cost share.

MAIL ORDER and RETAIL	<ul style="list-style-type: none"> The provider may call: 1-866-684-4488 or the completed form may be faxed to: 1-866-684-4477 The patient may attach the completed form to the prescription and mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954 or email the form only to: TPharmPA@express-scripts.com 	MTF	<ul style="list-style-type: none"> Non-formulary medications are available at MTFs only if both of the following are met: <ul style="list-style-type: none"> The prescription is written by a military provider or, at the discretion of the MTF, a civilian provider to whom the patient was referred by the MTF. The non-formulary medication is determined to be medically necessary. Please contact your local MTF for more information. There are no cost shares at MTFs.
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Step 1 Please complete patient and physician information (Please Print)

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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Step 2 1. Please explain why the patient cannot be treated with a formulary medication:

Please indicate which of the reasons below (1-4) applies to each of the formulary medications listed in the table. You **MUST** circle a reason **AND** supply a specific written clinical explanation for **EACH** formulary medication.

Formulary Medication	Reason	Clinical Explanation
Tricyclic antidepressants (e.g. amitriptyline)	1 2 3 4	
Cyclobenzaprine (Flexeril)	1 2 3 4	

Acceptable clinical reasons for not using a formulary medication are:

1. Use of the formulary medication is contraindicated (e.g., due to hypersensitivity).
2. The patient has experienced or is likely to experience significant adverse effects from the formulary medication.
3. Use of the formulary medication has resulted in or is likely to result in therapeutic failure.
4. The patient previously responded to Savella and changing to a formulary medication would incur an unacceptable clinical risk to the patient.

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

 Prescriber Signature _____ Date