Clinical Policy: Milnacipran (Savella)
Reference Number: CP.PMN.125
Effective Date: 08.01.12
Last Review Date: 05.19
Line of Business: Commercial, HIM, Medicaid

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(s)
Savella is indicated for the management of fibromyalgia.

Savella is not approved for use in pediatric patients.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) 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. If contraindication or intolerance to duloxetine, 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:
   Medicaid/HIM – 12 months
   Commercial – Length of Benefit

   B. Depression (off-label) (must meet all):
      1. Diagnosis of depression;
      2. Age ≥ 18 years;
3. Failure of a ≥ 8-week trial of one SSRI at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced;
4. Failure of two SNRIs at up to maximally indicated doses, each used for ≥ 8 weeks unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of a ≥ 8-week trial of another generic antidepressant (e.g., bupropion, TCA, mirtazapine, etc.) at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed 200 mg/day (2 tablets/day).

**Approval duration:**
- Medicaid/HIM – 12 months
- Commercial – Length of Benefit

**C. Other diagnoses/indications**
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. All Indications in Section I (must meet all):**
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 200 mg/day (2 tablets/day).

**Approval duration:**
- Medicaid/HIM - 12 months
- Commercial - Length of Benefit

**B. Other diagnoses/indications (must meet 1 or 2):**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   **Approval duration: Duration of request or 12 months (whichever is less);** or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**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 policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.**

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*
### Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/ Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>amitriptyline (Elavil®)</td>
<td>Fibromyalgia: 10 mg to 50 mg PO once daily</td>
<td>150 mg/day</td>
</tr>
<tr>
<td>cyclobenzaprine (Flexeril®)</td>
<td>Fibromyalgia: 10 mg PO every morning and 20 mg at bedtime</td>
<td>30 mg/day</td>
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<tr>
<td>bupropion (Wellbutrin®)</td>
<td>Depression: 100 mg PO three times daily</td>
<td>450 mg/day</td>
</tr>
<tr>
<td>bupropion SR (Wellbutrin SR®)</td>
<td>Depression: 150 mg PO twice daily</td>
<td>400 mg/day</td>
</tr>
<tr>
<td>bupropion XL (Wellbutrin XL®)</td>
<td>Depression: 150 - 300 mg PO once daily</td>
<td>450 mg/day</td>
</tr>
<tr>
<td>citalopram (Celexa®)</td>
<td>Depression: 20-40 mg PO once daily</td>
<td>40 mg/day</td>
</tr>
<tr>
<td>desvenlafaxine succinate (Pristiq®)</td>
<td>Depression: 50 mg PO once daily</td>
<td>50 mg/day</td>
</tr>
<tr>
<td>duloxetine (Cymbalta®)</td>
<td>Fibromyalgia: 60 mg PO once daily</td>
<td>60 mg/day</td>
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<tr>
<td>escitalopram (Lexapro®)</td>
<td>Depression: 20 mg PO daily</td>
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<tr>
<td>fluoxetine (Prozac®)</td>
<td>Depression: 20 mg PO once daily</td>
<td>80 mg/day</td>
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<tr>
<td>fluvoxamine (Luvox®)</td>
<td>Depression (off-label): 50 mg PO once daily</td>
<td>300 mg/day</td>
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<tr>
<td>mirtazapine (Remeron®)</td>
<td>Depression: 15 mg PO once daily</td>
<td>45 mg/day</td>
</tr>
<tr>
<td>paroxetine (Paxil®)</td>
<td>Depression: 10 mg PO once daily</td>
<td>50 mg/day</td>
</tr>
<tr>
<td>paroxetine SR (Paxil CR®)</td>
<td>Depression: 12.5 mg PO once daily</td>
<td>62.5 mg/day</td>
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<tr>
<td>sertraline (Zoloft®)</td>
<td>Depression: 50 mg PO once daily</td>
<td>200 mg/day</td>
</tr>
<tr>
<td>venlafaxine (Effexor®)</td>
<td>Depression: 75 mg PO once daily</td>
<td>375 mg/day</td>
</tr>
<tr>
<td>venlafaxine SR (Effexor XR®)</td>
<td>Depression: 37.5 mg PO once daily</td>
<td>225 mg/day</td>
</tr>
<tr>
<td>desvenlafaxine succinate (Pristiq®)</td>
<td>50 mg PO daily</td>
<td>50 mg/day</td>
</tr>
<tr>
<td>amitriptyline (Elavil®)</td>
<td>75 mg PO daily</td>
<td>150 mg/day</td>
</tr>
<tr>
<td>doxepin (Sinequan®)</td>
<td>75 mg PO daily</td>
<td>300 mg/day</td>
</tr>
<tr>
<td>imipramine (Tofranil®)</td>
<td>75 mg PO daily</td>
<td>200 mg/day</td>
</tr>
<tr>
<td>nortriptyline (Pamelor®)</td>
<td>50 mg PO daily</td>
<td>150 mg/day</td>
</tr>
<tr>
<td>trazodone (Desyrel®)</td>
<td>150 mg PO in divided doses daily</td>
<td>400 mg/day</td>
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</table>

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): Concomitant use or use within 14 days of discontinuing an MAOI used to treat psychiatric disorders, use of an MAOI within 5 days of discontinuing Savella, initiation of Savella in patients currently treated with linezolid or IV methylene blue due to increased risk of serotonin syndrome.
- Boxed Warning(s): increased risk of suicidal ideation, thinking, and behavior in children, adolescents, and young adults taking antidepressants for major depressive disorder (MDD) and other psychiatric disorders. Savella is not approved for use in pediatric patients.

Appendix D: General Information

- Class IIb recommendation in Micromedex for depression.
- Use of monoamine oxidase inhibitors (MAOI) with Savella concomitantly is contraindicated due to the risk of serious, sometimes, fatal, drug interactions with serotonergic drugs. These interactions have been associated with symptoms that include tremor, myoclonus, diaphoresis, nausea, vomiting, flushing, dizziness, hyperthermia with features resembling neuroleptic malignant syndrome, seizures, rigidity, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. Allow at least 14 days after stopping an MAOI before starting Savella. Allow at least 5 days after stopping Savella before starting an MAOI.
- Savella should be stopped promptly, and linezolid or intravenous methylene blue can be administered. The patient should be monitored for symptoms of serotonin syndrome for 5 days or until 24 hours after the last dose of linezolid or intravenous methylene blue, whichever comes first. Therapy with Savella may be resumed 24 hours after the last dose of linezolid or intravenous methylene blue.
- Serotonin syndrome: Serotonin syndrome has been reported with SNRIs and SSRIs. Concomitant use of serotonergic drugs is not recommended.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
</table>
| Fibromyalgia | Based on efficacy and tolerability, PO 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 PO (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. References

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria modified to require use of first line trials for ≥ 30 days within the previous 6 months</td>
<td>08.15</td>
<td>08.15</td>
</tr>
<tr>
<td>Updated references to reflect current literature search</td>
<td>02.16</td>
<td>05.16</td>
</tr>
<tr>
<td>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.</td>
<td>03.17</td>
<td></td>
</tr>
<tr>
<td>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; Updated references</td>
<td>02.06.18</td>
<td>05.18</td>
</tr>
<tr>
<td>2Q2018 annual review: polices combined for Medicaid, HIM, and Commercial lines of business; Medicaid &amp; HIM: Added off-label criteria for depression; changed from trial of 2 antidepressants to trial of one SSRI, two SNRI and one other antidepressant; Commercial: Added failure of amitriptyline or cyclobenzaprine if duloxetine cannot be used; references reviewed and updated</td>
<td>02.24.19</td>
<td>05.19</td>
</tr>
</tbody>
</table>
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.

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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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy; HIM.PA.103.

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