Clinical Policy: Fibromyalgia Agents

Reference Number: OH.PHAR.PPA.39
Effective Date: 01.01.2020
Last Review Date:
Line of Business: Medicaid

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

Description

CNS AGENTS: FIBROMYALGIA AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
PREGABALIN (generic for Lyrica®)	SAVELLA® (milnacipran)

FDA Approved Indication(s)

- Savella is indicated for the management of fibromyalgia
- Lyrica is indicated for:
  - Neuropathic pain associated with diabetic peripheral neuropathy
  - Postherpetic neuralgia (PHN)
  - Patients 1 month of age and older with partial onset seizures as adjunctive therapy
  - Fibromyalgia
  - Neuropathic pain associated with spinal cord injury

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 has had a trial of medications from no less than 2 of the following drug classes for at least 14 days each in the past 90 days (guidelines suggest use of multiple agents concurrently to manage the signs of fibromyalgia):
   a) Gabapentin
   b) Pregabalin
   c) Short and /or long acting opioids
   d) Skeletal muscle relaxants

e) SNRI's
f) SSRI's
g) Trazodone
g) Tricyclic antidepressants

4. Trial of medications from no less than two of the above drug classes unless any of the following:
   a. Allergy to at least two medications in different classes (see above) not requiring prior approval;
   b. Contraindication to all medications not requiring prior approval
   c. History of unacceptable/toxic side effects to at least two medications in different classes (see above) not requiring prior approval

Approval duration: 12 months

II. 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.CPA.09 CP.PMN.53 for Medicaid or evidence of coverage documents.

III. Appendices/General Information

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

*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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Pregabalin (Lyrica®)	Fibromyalgia 75mg PO BID titrated to 225mg BID	450mg/day

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): known hypersensitivity to pregabalin or any of its components Milnacipran is contraindicated with concurrent use of MAOI therapy.

• Boxed warning(s): none reported

IV. Dosage and Administration

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Savella® (milnacipran)	Fibromyalgia 12.5mg PO QD titrated to 100mg BID	200 mg/day

V. Product Availability

Drug Name	Availability
Savella® (milnacipran)	Tablets: 12.5mg, 25mg, 50mg, 100mg Titration pack: 12.5mg tablets (5) 25mg tablets (8) 50mg tablets (42)

VI. References

Refer to package insert

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	11.2019	

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.