



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Milnacipran

Page: 1 of 2

Effective Date: 6/1/2026

Last Review Date: 5/2026

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input type="checkbox"/> Florida Kids
	<input type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input type="checkbox"/> Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for milnacipran under the patient's prescription drug benefit.

Description:

FDA-approved Indications

Milnacipran is indicated for the management of fibromyalgia.
Milnacipran is not approved for use in pediatric patients.

Applicable Drug List:

Milnacipran

Policy/Guideline:

Coverage Criteria

Fibromyalgia

Authorization may be granted when the requested drug is being prescribed for the management of fibromyalgia when the following criteria is met:

- The patient is 18 years of age or older

Continuation of Therapy

Fibromyalgia

Authorization may be granted when the requested drug is being prescribed for the management of fibromyalgia when ALL of the following criteria are met:

- The patient is 18 years of age or older
- The patient has achieved or maintained a positive clinical response to the requested drug (e.g., improvement in pain)

Approval Duration and Quantity Restrictions:

Approval:

- Initial therapy: 6 months
- Renewals: 12 months

Quantity Level Limit: Reference Formulary for drug specific quantity level limits

References:

1. Savella [package insert]. North Chicago, IL: AbbVie Inc; May 2024.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2025. <https://online.lexi.com>. Accessed March 25, 2025.



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3. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: <https://www.micromedexsolutions.com/> (cited: 03/25/2025).