Lybalvi (olanzapine and samidorphan)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: *(**ALL** of the following must be met with chart notes submitted for all requests)*

- ❑ Patient is 18 years of age or older
- ❑ Diagnosis of one of the following:
  - Schizophrenia
  - Bipolar I disorder
- ❑ Trial and failure of at least two preferred atypical antipsychotic medications. One of them MUST be aripirazole **OR** lurasidone:

  Medication(s) Name: _____ Chart Note Page #: _____

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- ❑ Baseline body weight prior to starting Lybalvi:_____
- ❑ Patient is not concurrently using Lybalvi with opioids. Patient must be off short-acting opioids for at least 7 days, and long-acting opioids for 14 days.

Re-authorization Criteria: *(**ALL** of the following must be met with chart notes submitted for all requests)*

- ❑ Updated notes that support the continued clinical benefit of the medication must be submitted.
- ❑ The patient's increase in body weight is **NOT** more than 10% baseline body weight prior to start Lybalvi.
  - Updated body weight after starting Lybalvi:_____

Initial Authorization: Up to three (3) months
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION AND ATTESTATION TO THE FOLLOWING:

1. Benefits and potential harm of antipsychotic medications were discussed with the patient.
2. Routine monitoring for antipsychotic-related side effects.
3. Information provided is true and accurate to the best of my knowledge and included in patient's medical record.

_____ _____

Prescriber's Signature Date