

Prior Authorization Request Form for  
olanzapine/ samidorphan (**Lybalvi**)



**JOHNS HOPKINS**  
HEALTH PLANS

7231 Parkway Drive, Suite 100  
Hanover, MD 21076

**Fax completed form and  
applicable progress notes to:  
(410) 424-4037**

## USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**Questions?** Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

**Step 1** Please complete patient and physician information (please print):

<b>1</b> Patient Name:	_____	Physician Name:	_____
Address:	_____	Address:	_____
Sponsor ID #:	_____	Phone #:	_____
Date of Birth	_____	Secure Fax #:	_____

**Step 2** Please complete the clinical assessment:

1. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
2. Does the patient have a documented diagnosis of schizophrenia or bipolar 1 disorder?  Note: Non-FDA-approved uses are not approved including major depressive disorder, or other mood disorders.	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
3. Has the patient tried either olanzapine alone or olanzapine/fluoxetine combination (Symbyax generic) and experienced significant weight gain or other metabolic complications (for example, worsening diabetes, new sleep apnea, development of NASH or obesity hypoventilation syndrome)?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
4. Has the patient tried and failed either aripiprazole or ziprasidone?	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

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

\_\_\_\_\_ Prescriber Signature

\_\_\_\_\_ Date

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<b>For Internal Use Only</b>	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: