



Montana Healthcare Programs  
Drug Prior Authorization Coverage Criteria

Symbyax™ (olanzapine/fluoxetine)

**Review Criteria**

Member must meet all the following criteria:

- Subject to Preferred Drug List requirements
- Member must be at least 6 years of age
- Member must have diagnosis of either major depressive disorder or bipolar I depression
  - Diagnosis of major depressive disorder:
    - Member must have an inadequate response to 2 separate oral antidepressant therapies (refer to Preferred Drug List for preferred options)
  - Diagnosis of bipolar I depression:
    - Member must have an inadequate response to a preferred atypical antipsychotic (refer to Preferred Drug List for preferred options)

Limitations:

- Maximum daily dose allowed is 1.0