Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

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Montana Healthcare Programs Prior Authorization Request Form for Use of Lybalvi (olanzapine-samidorphan)™

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	Prescriber Fax:
Prescriber Name:	Prescriber Speciality (if applicable):	

Please complete below information for applicable situation, **Initiation** or **Continuation** of therapy:

☐ **INITIATION OF THERAPY**

Please check appropriate diagnosis:

☐ **Schizophrenia**
☐ **Bipolar 1 Disorder**

1. Member is at least 18 years of age: ☐ Yes ☐ No

2. Therapy must be prescribed by or in consult with a psychiatric specialist: ☐ Yes ☐ No

   ***Action Required*:** If prescriber is not in a specialty clinic or this is not written by a specialist, information on annual consult with appropriate specialist is required (please attach):

   Name of Specialist: _____ Contact Date: _____

3. Prior to initiating therapy, member has had **at least** a seven-day opioid-free interval from the last use of short-acting opioids AND **at least** a 14-day, opioid-free interval from the last use of long-acting opioids: ☐ Yes ☐ No

4. Member has had positive trial of olanzapine, but unacceptable weight gain (7%) seen within 12 weeks or less of starting treatment: ☐ Yes ☐ No
   - Starting weight prior to starting olanzapine: _____ Date: _____
   - Current/recent weight since starting olanzapine: _____ Date: _____

5. Member has documented trials, with inadequate response (or contraindication) to two (2) additional preferred antipsychotics at maximally tolerated doses, for at least 4 weeks: ☐ Yes ☐ No
   - Name/dose of drug: _____ Dates used: _____
   - Name/dose of drug: _____ Dates used: _____

Quantity Limitations:
Maximum dose is 1 tablet per day

Initial authorization will be issued for 6 months.

☐ **CONTINUATION OF THERAPY**

1. Member has been adherent to medication: ☐ Yes ☐ No

2. Member has show positive clinical outcome to medication (weight to have decreased or stabilized): ☐ Yes ☐ No

   Please provide current weight: _____

3. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A prescriber is a specialist

Reauthorization will be issued for 12 months.

Please complete form, including required attachments, and fax to:
1-800-294-1350

11/2021