US Family Health Plan
Prior Authorization Request Form for
Olanzapine / Samidorphan (Lybalvi)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1

Please complete patient and physician information (please print):

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?	☐ Yes Proceed to question **2**	☐ No **STOP** 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.**	☐ Yes Proceed to question **3**	☐ No **STOP** 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)?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Has the patient tried and failed either aripiprazole or ziprasidone?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3

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

Prescriber Signature _____ Date _____

[27 September 2023]