



Prior Authorization Approval Criteria
Department of Pharmacy Services

Generic Name: olanzapine and fluoxetine HCl

Brand Name: Symbyax

Medication Class: psychotropic agent

FDA Approved Uses: depressive episodes associated with bipolar disorder

Usual Dose:

	Symbyax 6/25	Symbyax 6/50	Symbyax 12/25	Symbyax 12/50
Olanzapine	6 mg	6 mg	12 mg	12 mg
Fluoxetine	25 mg	50 mg	25 mg	50 mg

Duration of Therapy: Indefinite

Criteria for Use: *(bullet points below are all inclusive unless otherwise noted)*

- Clinically documented depressive episodes with bipolar disorder.
- Must be on a stable dose of fluoxetine for at least one month.
- Must be on a stable dose of olanzapine for at least one month.
- Must be prescribed by a psychiatrist.

Contraindications:

- Hypersensitivity to fluoxetine.
- Hypersensitivity to olanzapine.
- Concomitant use with an MAOI or recent use of an MAOI within 14 days of use.
- Concomitant use with thioridazine or recent use within 5 weeks.

Not approved if:

- Patient does not meet the above stated criteria.
- Patient has any contraindications to the use of fluoxetine.
- Patient has any contraindications to the use of olanzapine.



P&T Approval: _____ Date: _____