Prior Authorization Approval Criteria

Symbyax (olanzapinee and fluoxetine HCl)

Generic Name: olanzapine and fluoxetine HCl

Brand Name: Symbyax

Medication Class: psychotropic agent

FDA Approved Uses:
- Acute Depressive Episodes Associated with Bipolar I Disorder
- Treatment Resistant Depression

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 or Treatment Resistant Depression .
- 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.

Criteria for continuation of therapy:
- Patient is tolerating and responding to medication and there continues to be a medical need for the medication.

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.

Approval Duration:

- Initial indefinite
- Renewal indefinite

Fallon Health Pharmacy and Therapeutics Committee approval: _____

Date: _____

Adopted: 11/18/04

Revised: 9/25/15

Effective: 11/25/15