# Clinical Policy: Olanzapine/Samidorphan (Lybalvi)

Reference Number: CP.PMN.265
Effective Date: 09.01.21
Last Review Date: 08.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Revision Log

**See Important Reminder at the end of this policy for important regulatory and legal information.**

## Description

Olanzapine/samidorphan (Lybalvi®) is combination of olanzapine, an atypical antipsychotic, and samidorphan, an opioid antagonist.

## FDA Approved Indication(s)

Lybalvi is indicated for the treatment of:

- Schizophrenia in adults
- Bipolar I disorder in adults
  - Acute treatment of manic or mixed episodes as monotherapy and as adjunct to lithium or valproate
  - Maintenance monotherapy treatment

## Policy/Criteria

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation® that Lybalvi is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. Bipolar Disorder and Schizophrenia** (must meet all)**:**

1. Diagnosis of bipolar disorder or schizophrenia;
2. Age ≥ 18 years;
3. Member meets one of the following (a, b, or c):*

   * *For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395*

   a. Request is for the treatment of a member in a State with limitations on step therapy in certain mental health settings (*see Appendix D*);
   b. Member must use olanzapine at up to maximally indicated doses, unless contraindicated to excipients, clinically significant adverse effects are experienced;
   c. Member has diabetes mellitus or body mass index (BMI) > 30 kg/m$^2$;
4. Member meets one of the following (a or b):*

   * *For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395*

   a. Request is for the treatment of a member in a State with limitations on step therapy in certain mental health settings (*see Appendix D*);

b. Failure of a 4-week trial of one additional preferred atypical antipsychotic (e.g., aripiprazole, ziprasidone, quetiapine, risperidone) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;

5. Dose does not exceed 20 mg olanzapine/10 mg samidorphan (1 tablet) per day.

**Approval duration: 12 months**

**B. Other diagnoses/indications** (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

## II. Continued Therapy

**A. Bipolar Disorder and Schizophrenia** (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Lybalvi for bipolar disorder or schizophrenia and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 20 mg olanzapine/10 mg samidorphan (1 tablet) per day.

**Approval duration: 12 months**

**B. Other diagnoses/indications** (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the

relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

## III. Diagnoses/Indications for which coverage is NOT authorized:

**A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

**B.** Dementia-related psychosis.

## IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

BMI: body mass index

FDA: Food and Drug Administration

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| aripiprazole (Abilify®) | **Bipolar Disorder and Schizophrenia**<br>Adults: 10 to 15 mg PO QD | 30 mg/day |
| olanzapine (Zyprexa®) | **Schizophrenia**<br>Initial: 5 to 10 mg PO QD; target: 10 mg PO QD<br><br>**Bipolar Disorder**<br>Monotherapy: 10 to 15 mg PO QD; adjunct to lithium or valproate: 10 mg PO QD | 20 mg/day |
| quetiapine (Seroquel®) | **Schizophrenia**<br>Initial: 25 mg PO BID; target: 400 to 800 mg/day<br><br>**Bipolar Disorder**<br>Initial: 50 mg PO BID; target: 400 to 800 mg/day | 800 mg/day |
| risperidone (Risperdal®) | **Schizophrenia**<br>Initial: 1 mg PO BID or 2 mg PO QD; target: 4 to 8 mg PO QD<br><br>**Bipolar Disorder**<br>2 to 3 mg PO QD | Schizophrenia: 16 mg/day<br><br>Bipolar Disorder: 6 mg/day |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| ziprasidone (Geodon®) | **Schizophrenia**<br>20 mg PO BID<br><br>**Bipolar Disorder**<br>Initial: 40 mg PO BID; target: 40 to 80 mg PO BID | 160 mg/day |

*Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.*

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): patients using opioids; patients undergoing acute opioid withdrawal; if Lybalvi is administered with lithium or valproate, refer to the lithium or valproate prescribing information for the contraindications for those products
- Boxed warning(s): increased mortality in elderly patients with dementia-related psychosis

*Appendix D: States with Limitations against Redirections in Certain Mental Health Settings*

| State | Step Therapy Prohibited? | Notes |
|---|---|---|
| AR | Yes | For the treatment of psychosis and serious mental illness through antipsychotic prescription drugs, no step therapies allowed. |
| NV | No | **Applies to Medicaid requests only** Failure of a 4-week trial of olanzapine or one preferred atypical antipsychotic (e.g., aripiprazole, ziprasidone, quetiapine, risperidone) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated. |
| TX | No | Failure of a 4-week trial of olanzapine or one preferred atypical antipsychotic (e.g., aripiprazole, ziprasidone, quetiapine, risperidone) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated. |

## V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| Schizophrenia | Initiate at 5 mg/10 mg or 10 mg/10 mg PO QD. The recommended dosage is 10 mg/10 mg, 15 mg/10 mg, or 20 mg/10 mg. Dosage may be adjusted at weekly intervals of 5 mg (based on the olanzapine component) depending upon clinical response and tolerability. | 20 mg/10 mg/day |
| Bipolar I disorder | Monotherapy: Initiate at 10 mg/10 mg or 15 mg/10 mg PO QD. The recommended dosage is 10 mg/10 mg, 15 mg/10 mg, or 20 mg/10 mg PO QD. Dosage adjustments should occur at intervals of not less than 24 hours. When dosage adjustments are necessary, | 20 mg/10 mg/day |

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| | dose increments/decrements of 5 mg (based on the olanzapine component) are recommended.<br><br>Maintenance monotherapy: Administer at 5 mg/10 mg, 10 mg/10 mg, 15 mg/10 mg, or 20 mg/10 mg PO QD.<br><br>Adjunctive to lithium or valproate: Initiate at 10 mg/10 mg PO QD. The recommended dosage is 10 mg/10 mg, 15 mg/10 mg or 20 mg/10 mg PO QD. Dosage may be adjusted at weekly intervals of 5 mg (based on the olanzapine component), depending upon clinical response and tolerability. | |

## VI. Product Availability

Tablets (olanzapine/samidorphan): 5 mg/10 mg, 10 mg/10 mg, 15 mg/10 mg, 20 mg/10 mg

## VII. References

1. Lybalvi Prescribing Information. Waltham, MA: Alkermes, Inc.; January 2026. Available at: https://www.lybalvi.com/. Accessed April 21, 2026.
2. Keepers G, Fochtmann L, Anzia J, et al. American Psychiatric Association practice guideline for the treatment of patients with schizophrenia, third edition (2020). Available at: https://psychiatryonline.org/doi/10.1176/appi.books.9780890424841. Accessed May 29, 2026.
3. McDonagh MS, Dana T, Selph S, Devine EB, et al. Treatments for schizophrenia in adults: A systematic review. Comparative Effectiveness Review No. 198. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2015-00009-I.) AHRQ Publication No. 17(18)-EHC031-EF. Rockville, MD: Agency for Healthcare Research and Quality; October 2017.
4. Hirschfield RMA, Bowden CL, Gitlin MJ, et al. American Psychiatric Association practice guideline for the treatment of patients with bipolar disorder, second edition (2010). Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar.pdf . Accessed May 29, 2026.
5. Butler M, Urosevic S, Desai P, et al. Treatment for bipolar disorder in adults: A systematic review. Comparative Effectiveness Review No. 208. (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-2012-00016-I.) AHRQ Publication No. 18-EHC012-EF. Rockville, MD: Agency for Healthcare Research and Quality; August 2018.
6. Management of bipolar disorder work group. Clinical practice guideline for management of bipolar disorder Version 2.0 - 2023. Veterans Affairs/Department of Defense. Available at: https://www.healthquality.va.gov/guidelines/MH/bd/VA-DoD-CPG-BD-Full-CPGFinal508.pdf. Accessed May 29, 2026.

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| 3Q 2022 annual review: no significant changes; references reviewed and updated. | 05.12.22 | 08.22 |
| Template changes applied to other diagnoses/indications. | 10.07.22 | |
| Added redirection bypass for members in a State with limitations on step therapy in certain mental health settings along with Appendix D, which includes Arkansas. | 07.05.23 | |
| 3Q 2023 annual review: no significant changes; addition of dementia-related psychosis to Section III; added Texas to Appendix D with requirements for single drug redirection for HIM requests; references reviewed and updated. | 07.13.23 | 08.23 |
| Added Nevada to Appendix D with requirements for single drug redirection for Medicaid requests. | 08.31.23 | |
| 3Q 2024 annual review: no significant changes; references reviewed and updated. | 05.10.24 | 08.24 |
| 3Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated. | 06.27.25 | 08.25 |
| Removed "applies to HIM request only" from Appendix D for Arkansas per AR HB 1276. | 02.13.26 | |
| 3Q 2026 annual review: added ICHRA line of business; removed all line of business-specific distinctions" from Appendix D; references reviewed and updated. | 04.21.26 | 08.26 |
| Added Medicaid-specific distinction to NV in Appendix D per VPRP request and Compliance. | 10.28.26 | |

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note:**
**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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