PRIOR AUTHORIZATION REQUEST

OAB and NDO Agents

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is the request an INITIAL or CONTINUATION of therapy?
[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

If you have any questions, call: 1-888-258-8250

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has experienced a clinically significant improvement in symptoms with therapy, as determined by the provider (e.g., reduced incontinence episodes, urgency)? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the indication? [] Overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, and urinary frequency (If checked, go to question 8) [] Neurogenic Detrusor Overactivity (Neurogenic Bladder) (NDO) (If checked, go to question 26) [] Other (If checked, no further questions)		
8	Has the patient experienced symptoms of overactive bladder (OAB) for at least 3 months? [If no, no further questions.]	Yes	No
9	Has documentation been submitted to support the condition of overactive bladder? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	What medication is being requested? [] Myrbetriq (Mirabegron) (If checked, go to question 11) [] Gemtesa (Vibegron) (If checked, go to question 13) [] Toviaz (Fesoterodine) (If checked, go to question 18) [] Vesicare (Solifenacin) (If checked, go to question 19) [] Enablex (Darifenacin) (If checked, go to question 21)		

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11	Does the patient have a history of myocardial infarction in the preceding 2 years? [If yes, no further questions.]	Yes	No
12	Is the patient currently on a concomitant CYP3A4 inhibitor (e.g., ketoconazole, itraconazole, ritonavir)? [If yes, no further questions.] [If no, skip to question 16.]	Yes	No
13	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
14	Is this request for a female patient who is pregnant or breastfeeding? [If yes, no further questions.]	Yes	No
15	Is this request for a male patient receiving pharmacological therapy for benign prostatic hyperplasia (BPH)? [If yes, no further questions.]	Yes	No
16	Does the patient have a history of uncontrolled hypertension? [If yes, no further questions.]	Yes	No
17	Does the patient have end-stage renal disease (creatinine clearance [CrCl] less than 15 mL/min or on dialysis)? [If yes, no further questions.] [If no, skip to question 22.]	Yes	No
18	Does the patient have urinary/gastric retention or uncontrolled narrow-angle glaucoma? [If yes, no further questions.] [If no, skip to question 20.]	Yes	No
19	Does the patient have a history of QT prolongation or severe renal impairment? [If yes, no further questions.]	Yes	No
20	Does the patient have a history of severe hepatic impairment (Child-Pugh Class C)? [If yes, no further questions.] [If no, skip to question 22.]	Yes	No
21	Does the patient have a history of GI obstruction, ulcerative colitis, or myasthenia gravis? [If yes, no further questions.]	Yes	No
22	Has the patient tried and failed behavioral therapies such as bladder training, pelvic muscle training, or adjusting the amount of fluid consumed? [If no, no further questions.]	Yes	No
23	Has the patient tried and failed, or has a contraindication to, all the following	Yes	No

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	preferred formulary options: Oxybutynin chloride, Tolterodine tartrate, Trospium chloride? ACTION REQUIRED: Submit supporting documentation [If no, no further questions.]		
24	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [If yes, no further questions.]	Yes	No
25	Is the medication being prescribed by or in consultation with a urologist or specialist in the treatment of overactive bladder? [No further questions.]	Yes	No
26	Is the patient between 2 and 17 years of age? [If no, no further questions.]	Yes	No
27	Has the diagnosis been confirmed and supported by urodynamic studies and adjunct tests to confirm neurological involvement? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
28	What medication is being requested? [] Myrbetriq (Mirabegron) (If checked, go to 29) [] Toviaz (Fesoterodine) (If checked, go to 35) [] Vesicare (Solifenacin) (If checked, go to 36) [] Other (If checked, no further questions)		
29	Is the patient 3 years of age or older? [If no, no further questions.]	Yes	No
30	Does the patient have a history of uncontrolled hypertension? [If yes, no further questions.]	Yes	No
31	Does the patient have a history of severe hepatic impairment? [If yes, no further questions.]	Yes	No
32	Does the patient have end-stage renal disease (creatinine clearance [CrCl] less than 15 mL/min or on dialysis)? [If yes, no further questions.]	Yes	No
33	Does the patient have a history of myocardial infarction in the preceding 2 years? [If yes, no further questions.]	Yes	No
34	Is the patient currently using a strong CYP3A4 inhibitor (e.g., ketoconazole, itraconazole, ritonavir)?	Yes	No

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	[If yes, no further questions.] [If no, skip to question 37.]		
35	Is the patient 6 years of age or older? [If yes, skip to question 37.] [If no, no further questions.]	Yes	No
36	Is the patient 2 years of age or older? [If no, no further questions.]	Yes	No
37	Has the patient tried and failed behavioral therapies (for example, scheduled routine to urinate)? [If no, no further questions.]	Yes	No
38	Has the patient tried and failed oxybutynin for at least 3 months or has documentation been provided to confirm that the patient had an intolerance or has a contraindication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
39	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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