**Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.**
**Overactive Bladder Agents, Beta-3 Adrenergic receptor (Myrbetriq & Gemtesa)**
**Prior Authorization (PA)**
**Pharmacy Benefits Prior Authorization Help Desk**
**Length of Authorizations: Initial- 12 months; Continuation- 12 months**

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Overactive Bladder Agents, Beta-3 Adrenergic receptor (Myrbetriq & Gemtesa).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

**KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html**

**1 – Patient Information**

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

**2 – Prescriber Information**

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

**3 – Pharmacy Information**

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

**5– Diagnosis/Clinical Criteria**

1. Is this request for initial or continuing therapy?
□ Initial therapy □ Continuing therapy, State date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

3. Does the member have a diagnosis of overactive bladder, urge incontinence, urgency, urinary frequency or bladder spasm, **AND**
   □ No □ Yes

4. Did the member have an inadequate response*, intolerance**, contraindication to antimuscarinics or history of trial and failure of ≥ 2 of the following***
   i. Oxybutynin OTC patch, oxybutynin IR/ER, solifenacin, darifenacin, tolterodine IR/ER, trospium IR/XR
   □ No □ Yes

*** Additional question for Gemtesa Only***

5. Has the patient had an inadequate response*, intolerance**, contraindication, or history of trial and failure to Myrbetriq (mirabegron)
   □ No □ Yes

**For continuation of therapy, please respond to additional questions below.**

1. Patients previously taking mirabegron with good clinical response and history of trial and failure, inadequate response, intolerance, or contraindication to ≥ 2 of the following:
   ☐ Oxybutynin OTC patch
   ☐ oxybutynin IR/ER
   ☐ solifenacin
   ☐ darifenacin
   ☐ tolterodine IR/ER
   ☐ trospium IR/XR
   □ No □ Yes

**Additional question for Gemtesa Only:**

2. Has the patient had an inadequate response*, intolerance**, contraindication, or history of trial and failure to Myrbetriq (mirabegron)
   □ No □ Yes

**NOTES:**

*An inadequate response is defined as no reduction of episodes of frequency or incontinence per day from baseline after an adequate trial period of 4-6 weeks.

** Intolerance excludes adverse drug reactions that are expected, mild in nature, resolve with continued treatment and do not require medication discontinuation

*** Alternative antimuscarinics:

- Promote use of OTC products when possible
- When available, ER formulations are preferred over IR formulations
- KPMAS prescription antimuscarinic treatment algorithm for overactive bladder is as follows:

| Age | 1st Line | 2nd Line |
|---|---|---|
| | Agents listed in order of preference | |
| Age < 65 years | • Oxybutynin ER<br>• Solifenacin | • Darifenacin<br>• Tolterodine ER |
| Age ≥ 65 years | • Solifenacin | • Darifenacin<br>• Tolterodine ER |

## 6 – Prescriber Sign-Off

**Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. If no to any of the above questions, please provide any additional supporting information that should be taken into consideration:**

_____

_____

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

| **Prescriber Signature:** | **Date:** |
|---|---|
| | |

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