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 • Solifenacin	• Darifenacin • Tolterodine ER
Age ≥ 65 years	• Solifenacin	• Darifenacin • 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:**