Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Myrbetriq (mirabegron) 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 **Myrbetriq (mirabegron)** for **Commercial, Exchange, FEHB (Federal),** and **MD Medicaid** plans**.** 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: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: ______________________________ Kaiser Medical ID#: _________________ Date of Birth: _____________

2 – Prescriber Information

Prescriber Name: ______________________________ Specialty: ____________________________ NPI: _________________

Prescriber Address: ____

Prescriber Phone #: __________________________Prescriber Fax #: ___________________________

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: ________________

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: ___________________________________

Clinical Criteria:

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

2. Did the member have a contraindication to antimuscarinic therapy (e.g., history of uncontrolled tachyarrhythmias, myasthenia gravis, gastric retention, and/or narrow angle-closure glaucoma), an inadequate response*, intolerance**, or history of trial and failure of ≥ 2 of the following***
   a. Oxybutynin OTC patch, oxybutynin IR/ER, solifenacin, darifenacin, tolterodine IR/ER, trospium IR/XR
   □ No □ Yes

3. If ordering brand Myrbetriq tablets: does the patient have a history of contraindication, intolerance*, or inadequate response** to generic mirabegron ER tablets?
   □ No □ Yes

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

1. Was the patient previously taking mirabegron with good clinical response, and has contraindication to antimuscarinic therapy (e.g., history of uncontrolled tachyarrhythmias, myasthenia gravis, gastric retention, and/or narrow angle-closure glaucoma), inadequate response, intolerance, or history of trial and failure of ≥ 2 of the following:
   ☐ Oxybutynin OTC patch
   ☐ oxybutynin IR/ER
   ☐ solifenacin
   ☐ darifenacin
   ☐ tolterodine IR/ER
   ☐ trospium IR/XR
   □ No □ Yes

2. If ordering brand Myrbetriq tablets: does the patient have a history of contraindication, intolerance*, or inadequate response** to generic mirabegron ER tablets?
   □ 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
- When antimuscarinic therapy is selected, trospium or darifenacin is preferred to potentially minimize risk of cognitive impact [other antimuscarinic therapies, such as oxybutynin products, are suitable for short-term use (i.e. postsurgical stent or spasm management)]
- 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 –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

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____ **I**

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

Prescriber Signature:	**Date:**

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