Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Gemtesa (vibegron) 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 **Gemtesa (vibegron)** 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. 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 <u>additional questions</u> below:

1. Patients previously taking mirabegron with good clinical response and 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. Has the patient had an inadequate response*, intolerance**, contraindication, or history of trial and failure to Myrbetriq (mirabegron)?
   □ No □ Yes

<u>NOTES:</u>

*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:**

_____

_____

_____

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

Prescriber Signature:	**Date:**