

# SENTARA HEALTH PLANS

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST\*

**Directions:** The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

### Overactive Bladder Drugs

**Drug Requested:** select one drug below

<input type="checkbox"/> <b>fesoterodine</b> (Toviaz®)	<input type="checkbox"/> <b>Gemtesa</b> ® (vibegron)	<input type="checkbox"/> <b>mirabegron</b> (Myrbetriq®)
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**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

Member Name: \_\_\_\_\_

Member Sentara #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

NPI #: \_\_\_\_\_

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

Drug Name/Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

Weight (if applicable): \_\_\_\_\_ Date weight obtained: \_\_\_\_\_

**Quantity Limits:** 1 tablet per day (all strengths & medications)

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

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**Diagnosis: Overactive Bladder (OAB)**

- ❑ For diagnosis of overactive bladder with symptoms of urge urinary incontinence, urgency, and urinary frequency in adults, member must have documentation of **at least a 30-day** trial and failure of **TWO (2)** of the following (**check each that have been tried**):

<input type="checkbox"/> oxybutynin IR/ER	<input type="checkbox"/> darifenacin
<input type="checkbox"/> tolterodine IR/ER	<input type="checkbox"/> solifenacin tablets
<input type="checkbox"/> trospium IR/ER	

**Diagnosis: OAB with Benign Prostatic Hyperplasia (BPH)**

- ❑ **If requesting mirabegron (Myrbetriq®):** For a diagnosis of overactive bladder with symptoms of urge urinary incontinence, urgency, and urinary frequency in adults and adult males on pharmacological therapy for benign prostatic hyperplasia, member must have documentation of **at least a 30-day** trial and failure of **ONE** of the following (**check each that have been tried**):

<input type="checkbox"/> doxazosin	<input type="checkbox"/> silodosin
<input type="checkbox"/> alfuzosin	<input type="checkbox"/> tamsulosin
<input type="checkbox"/> dutasteride and tamsulosin	<input type="checkbox"/> terazosin

- ❑ **If requesting Gemtesa® (vibegron):** For a diagnosis of overactive bladder with symptoms of urge urinary incontinence, urgency, and urinary frequency in adults and adult males on pharmacological therapy for benign prostatic hyperplasia, member must meet **BOTH** of the following:

- ❑ Member must have documentation of **at least a 30-day** trial and failure of **ONE** of the following (**check each that have been tried**):

<input type="checkbox"/> doxazosin	<input type="checkbox"/> silodosin
<input type="checkbox"/> alfuzosin	<input type="checkbox"/> tamsulosin
<input type="checkbox"/> dutasteride and tamsulosin	<input type="checkbox"/> terazosin

**AND**

- ❑ Member must have documentation of **at least a 30-day** trial and failure of mirabegron (generic Myrbetriq®)

*Not all drugs may be covered under every Plan*

*If a drug is non-formulary on a Plan, documentation of medical necessity will be required.*

***\*\*Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.\*\****

***\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.\****