AvMed

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 1-305-671-0200**. 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

❑ **fesoterodine** (Toviaz®)	❑ **Gemtesa®** (vibegron)	❑ **mirabegron** (Myrbetriq®)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **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.

(Continued on next page)

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)**:

❑ oxybutynin IR/ER	❑ darifenacin
❑ tolterodine IR/ER	❑ solifenacin tablets
❑ 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)**:

❑ doxazosin	❑ silodosin
❑ alfuzosin	❑ tamsulosin
❑ dutasteride and tamsulosin	❑ 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)**:

❑ doxazosin	❑ silodosin
❑ alfuzosin	❑ tamsulosin
❑ dutasteride and tamsulosin	❑ 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.****

***Approved by Pharmacy and Therapeutics Committee**: ~~4/17/2014;~~ **1/23/2025**
REVISED/UPDATED/REFORMATTED: ~~12/31/2016; 8/16/2017; 2/15/2019; 8/31/2020; 3/8/2021; 6/3/2021; 11/1/2023;~~ **2/19/2025**