HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
OVERACTIVE BLADDER
Myrbetriq®, Toviaz®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

For Commercial Groups, Individual & Family Plans please fax request to 888-509-8142.
For Healthy U Medicaid, University of Utah Health Employees please fax request to 844-316-3655

If you have prior authorization questions, please call for assistance: Healthy U: 866-236-5935, University of Utah Health Employees: 866-861-6178, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being request: ☐ Myrbetriq® (mirabegron), ☐ Toviaz® (fesoterodine)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a confirmed diagnosis of overactive bladder?	☐	☐	**Please provide documentation**
2. Does the member have symptoms of urinary incontinence, urgency and urinary frequency?	☐	☐	**Please provide documentation**
3. Has the member tried and failed behavioral therapies, such as bladder training, bladder control strategies, fluid management, etc.? (Not required in the setting of neurogenic bladder)	☐	☐	**Please provide documentation**
4. Has the member tried and failed at least 3 other antimuscarinic agents, such as darifenacin, oxybutynin and tolterodine?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Has the therapy been shown to be effective with an improvement in condition?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician's Signature:

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Policy PHARM-097
Origination Date: 01/22/2020
Reviewed/Revised Date: 03/25/2020
Next Review Date: 03/25/2021
Current Effective Date: 06/28/2020