

Bladder Relaxant – Clinical Prior Authorization (PA) Request Form
CT Medical Assistance Program
To Be Completed By Prescriber

<u>Prescriber Information</u>	<u>Patient Information</u>
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Prescriber Subspecialty:	Patient DOB:
Phone ()	Patient Current Weight:
Fax ()	Patient Primary ICD Diagnosis Code:
<u>Prescription Information</u>	
Drug, Strength, and Dosage Form Requested:	Frequency of Dosing:
<input type="checkbox"/> New therapy <input type="checkbox"/> Continuation	Quantity Requested:

Clinical Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet authorization requirements

<u>Preferred Agents:</u>	<u>Non-Preferred Agents:</u>
FESOTERODINE ER TABLET MYRBETRIQ ER TABLET (BRAND PREFERRED) OXYBUTYNIN ER TABLET OXYBUTYNIN SOLUTION OXYBUTYNIN TABLET (not 2.5MG) SOLIFENACIN TABLET	DARIFENACIN ER TABLET OXYTROL FOR WOMEN OTC DETROL TABLET TOLTERODINE ER CAPSULE DETROL LA CAPSULE TOLTERODINE TABLET FLAVOXATE TABLET TOVIAZ ER TABLET GEMTESA TABLET TROSPIUM TABLET MIRABEGRON ER TABLET TROSPIUM ER CAPSULE MYRBETRIQ ER SUSPENSION VESICARE TABLET OXYBUTYNIN 2.5 MG TABLET VESICARE LS SUSPENSION OXYTROL PATCH (RX)
Patient has trialed and failed ONE preferred agent (minimum 30 days): <ul style="list-style-type: none"> <input type="radio"/> Preferred agent trialed: _____ <input type="radio"/> Trial Dates: _____ <input type="radio"/> Reason for Contraindication or Failure: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No

For Initial Approval:
Medication Requested and diagnosis of ONE of the following:

(attach supporting documentation, required)

<p><u>Darifenacin ER (Enablex):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Overactive Bladder (OAB) with symptoms of Urge Urinary Incontinence (UUI) including urgency and frequency AND • Failure to achieve desired therapeutic outcomes with a trial of one preferred agent (as outlined above in Clinical Information section) 	<p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><u>Detrol IR or Detrol LA (tolterodine):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Overactive Bladder (OAB) with symptoms of Urge Urinary Incontinence (UUI) including urgency and frequency AND • Failure to achieve desired therapeutic outcomes with a trial of one preferred agent (as outlined above in Clinical Information section) AND 	<p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><u>Flavoxate (Urispas) (Patients 12+ years):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of dysuria, urgency, nocturia, suprapubic pain, frequency and incontinence as may occur in cystitis, prostatitis, urethritis, urethrocystitis/urethrotrigonitis AND • Failure to achieve desired therapeutic outcomes with a trial of one preferred agent (as outlined above in Clinical Information section) 	<p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><u>Gemtesa (Vibegron) (Patients 18+ years):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Overactive Bladder (OAB) with symptoms of Urge Urinary Incontinence (UUI) including urgency and frequency with or without benign prostatic hyperplasia (BPH) AND • Failure to achieve desired therapeutic outcomes with a trial of one preferred agent (as outlined above in Clinical Information section) 	<p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><u>Mirabegron ER Tablet (Mybetriq ER) (Patients 3+ years):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Overactive Bladder (OAB) with symptoms of Urge Urinary Incontinence (UUI) including urgency and frequency, alone or in combination with solifenacin succinate OR 	<p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<ul style="list-style-type: none"> • Patient has a documented diagnosis of Neurogenic Detrusor Overactivity (NDO) AND • Failure to achieve desired therapeutic outcomes with a trial of one preferred agent (as outlined above in Clinical Information section) AND • Documented medical reason why BRAND preferred formulation cannot be used: _____ 	
<p><u>Mybetriq ER Suspension Granules (Mirabegron) (Patients 3+ years):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Neurogenic Detrusor Overactivity (NDO) AND • Documented medical reason why preferred TABLET formulation cannot be used: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Oxybutynin 2.5mg Tablet (Ditropan IR):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of bladder instability associated with voiding in patients with uninhibited neurogenic or reflex neurogenic bladder AND • Failure to achieve desired therapeutic outcomes with a trial of one preferred agent (as outlined above in Clinical Information section) AND • Documented medical reason why preferred 5MG TABLET formulation cannot be used: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Oxytrol (RX Transdermal Oxybutinin):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Overactive Bladder (OAB) in men with symptoms of Urge Urinary Incontinence (UUI) including urgency and frequency AND • Failure to achieve desired therapeutic outcomes with a trial of one preferred agent (as outlined above in Clinical Information section) AND • Documented medical reason why preferred ORAL formulations cannot be used: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Oxytrol for Women (OTC Transdermal Oxybutinin) (Patients 18+ years):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Overactive Bladder (OAB) in women AND • Failure to achieve desired therapeutic outcomes with a trial of one preferred agent (as outlined above in Clinical Information section) AND • Documented medical reason why preferred ORAL formulations cannot be used: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p><u>Tolterodine IR and ER (Detrol IR or ER formulations):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Overactive Bladder (OAB) with symptoms of Urge Urinary Incontinence (UII) including urgency and frequency AND • Failure to achieve desired therapeutic outcomes with a trial of one preferred agent (as outlined above in Clinical Information section) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Toviaz ER (fesoterodine) (Patients 6+):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Overactive Bladder (OAB) with symptoms of Urge Urinary Incontinence (UII) including urgency and frequency OR • Patient has a documented diagnosis of Neurogenic Detrusor Overactivity (NDO) AND • Failure to achieve desired therapeutic outcomes with a trial of one preferred agent (as outlined above in Clinical Information section) AND • Documented medical reason why GENERIC preferred formulation cannot be used: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Trospium IR and ER (Sanctura IR or ER formulations):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Overactive Bladder (OAB) with symptoms of Urge Urinary Incontinence (UII) including urgency and frequency AND • Failure to achieve desired therapeutic outcomes with a trial of one preferred agent (as outlined above in Clinical Information section) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Vesicare (solifenacin) (Patients 2+ years):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Overactive Bladder (OAB) with symptoms of Urge Urinary Incontinence (UII) including urgency and frequency AND • Failure to achieve desired therapeutic outcomes with a trial of one preferred agent (as outlined above in Clinical Information section) • Documented medical reason why GENERIC preferred formulation cannot be used: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Vesicare LS (Solifenacin Suspension) (Patients 2+ years):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Neurogenic Detrusor Overactivity (NDO) • Documented medical reason why preferred TABLET formulation cannot be used: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No

Renewal Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet renewal authorization requirements

<ul style="list-style-type: none"> • Has the patient previously met the required criteria set forth in Initial Approval Section above? <ul style="list-style-type: none"> ○ Previous Approved Prior Authorization Number: _____ ○ Approval Dates: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> • Patients' clinical response to treatment and ongoing safety has been documented and monitored 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> • Prescriber attests that the patient has a continued need for therapy and is compliant with current regimen 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> • For specific formulation requests: <ul style="list-style-type: none"> ○ For brand requests when a therapeutically equivalent generic is preferred: Provider must provide a documented medical reason the preferred generic formulation cannot be used _____ ○ For generic requests when a therapeutically equivalent brand is preferred: Provider must provide a documented medical reason the preferred brand formulation cannot be used _____ ○ For non-preferred dosage or formulation requests: Provider must provide a documented medical reason the preferred dosage or formulation cannot be used _____ 	

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission. I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that a prior authorization may not exceed one (1) year from the date of fill for non- controlled medications. Authorizations for Early Refill Requests are valid one time only.

Prescriber Signature*: _____ **Date:** _____

*** Mandatory (others may not sign for prescriber). In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**

This form (and attachments) contains protected health information (PHI) for Gainwell Technologies and is covered by the Electronic Communications Privacy Act, 18 U.S.C. § 2510-2521 and the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, which is intended only for the use of prior authorization. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited. Any unintended recipient should contact Gainwell Technologies by telephone at (860) 255-3900 or by e-mail immediately and destroy the original message.