US Family Health Plan
Prior Authorization Request Form for
vibegron **(Gemtesa)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1

Please complete patient and physician information (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2

Please complete the clinical assessment:

1. Does the patient have a confirmed diagnosis of overactive bladder with symptoms of urge incontinence, urgency, and urinary frequency?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Has the patient tried and failed behavioral interventions to include such as pelvic floor muscle training in women, AND bladder training?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient had a 12-week trial of ONE of the following medications AND experienced therapeutic failure? • **tolterodine extended-release (Detrol LA)** • **oxybutynin IR** • **oxybutynin ER** • **trospium (Sanctura)** • **solifenacin (Vesicare)** • **darifenacin (Enablex)** • **fesoterodine (Toviaz)**	☐ Yes Proceed to Question **5**	☐ No Proceed to Question **4**
4. Has the patient experienced central nervous system (CNS) adverse effects with an oral overactive bladder (OAB) medication or is at increased risk for CNS adverse effects due to comorbid conditions, advanced age or other medications?	☐ Yes Proceed to Question 5	☐ No **STOP** **Coverage not approved**
5. Is the patient's estimated glomerular filtration rate (eGFR) available? If so please provide the eGFR. Note: eGFR must be greater than or equal to 15 mL/min/1.73m2 for coverage of Gemtesa	☐ _____mL/min/1.73m2 **Sign and date below**	☐ eGFR not available Proceed to Question **6**

6. What is the patient's serum creatinine (SCr), weight, and height? Note: CrCl must be greater than or equal to 15 mL/min/1.73m2 for coverage of Gemtesa	_____ mg/dL or _____mmols/L _____ inches AND _____lbs **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____

Prescriber Signature Date