

USFHP Prior Authorization Request Form for mirabegron tablets (**Myrbetriq**)

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

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Please note that there is a separate prior authorization form for Myrbetriq granules. Clinical documentation may be required.

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 Proceed to question 7
2. Has the patient tried and failed behavioral interventions to include 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 creatinine clearance (CrCl)/glomerular filtration rate (eGFR) greater than or equal to 15 mL/min/1.73m2?	☐ Yes Proceed to Question 6	☐ No STOP Coverage not approved

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6. Is the provider aware that the dosage of Myrbetriq should not exceed 25 mg daily when the CrCl/ glomerular filtration rate (eGFR) is between 15-29 mL/min/1.73m2?	☐ Yes Proceed to question 14	☐ No STOP Coverage not approved
7. Does the patient have a diagnosis of neurogenic detrusor overactivity (NDO) secondary to detrusor overactivity and/or myelomeningocele?	☐ Yes Proceed to Question 8	☐ No STOP Coverage not approved
8. Is the medication being prescribed by or in consultation with a urologist or nephrologist?	☐ Yes Proceed to Question 9	☐ No STOP Coverage not approved
9. Does the provider acknowledge that the granules are not bioequivalent to and cannot be substituted on a mg to mg basis to the tablets and will not combine dosage forms to achieve a specific dose?	☐ Acknowledged Proceed to question 10	
10. Does the provider acknowledge that there are detailed renal and hepatic dose adjustments in the package labeling and agrees to consult this before prescribing in these special populations?	☐ Acknowledged Proceed to question 11	
11. Does the provider acknowledge that oxybutynin is available for patients with neurogenic detrusor overactivity and does not require prior authorization?	☐ Acknowledged Proceed to question 12	
12. Has the patient tried and failed or had a contraindication to oxybutynin?	☐ Yes Proceed to Question 13	☐ No STOP Coverage not approved
13. Does the patient weigh greater than or equal to 35 kg?	☐ Yes Proceed to question 14	☐ No STOP Coverage not approved
14. Does the provider acknowledge that the brand Myrbetriq tablet is the preferred product over generic mirabegron tablet and is covered at the lowest copayment, which is the generic formulary copayment for non-Active-Duty patients, and at no cost share for Active-Duty patients. (Although Myrbetriq is a branded product, it will be covered at the generic formulary copayment or cost share)	☐ Acknowledged Proceed to question 15	
15. What is the requested medication?	☐ Myrbetriq tablets - Sign and date below ☐ mirabegron tablets (generic Myrbetriq) - Proceed to question 16 ☐ Other – STOP Coverage not approved	
16. Please provide a patient-specific justification as to why the brand Myrbetriq cannot be used in this patient.	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