US Family Health Plan
Prior Authorization Request Form for
mirabegron for extended-release oral suspension **(Myrbetriq Granules)**

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:

Question		
1. Is the requested medication prescribed by or in consultation with a urologist or nephrologist?	☐ Yes Proceed to Question **2**	☐ No **STOP** **Coverage not approved**
2. What is the diagnosis or indication?	☐ Neurogenic bladder secondary to detrusor overactivity and/or myelomeningocele – proceed to question **3** ☐ Overactive bladder – **STOP: Coverage not approved** ☐ Other – **STOP: Coverage not approved**	
3. Does the provider acknowledge that oxybutynin oral syrup is available for patients with neurogenic detrusor overactivity and does not require prior authorization?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and failed or had a contraindication to oxybutynin?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. What is the reason that patient requires granules for oral suspension?	☐ Patient cannot swallow due to some documented medical condition - dysphagia, oral candidiasis, systemic sclerosis, etc. – proceed to question **6** ☐ Patient weighs less than 35 kg - proceed to question **6** ☐ Convenience – **STOP: Coverage not approved** ☐ Other – **STOP: Coverage not approved**	
6. Does the provider acknowledge that 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?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7.	**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?**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _______________ Date _______________