US Family Health Plan

Prior Authorization Request Form for

tolterodine IR (**Detrol**), darifenacin (**Enablex**), oxybutynin gel (**Gelnique**), oxybutynin transdermal patch (**Oxytrol**), trospium ER (**Sanctura/Sanctura XR**), fesoterodine (**Toviaz**), solifenacin tablet (**Vesicare**)

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. What medication is being requested?	☐ OTC Oxytrol for Women - Proceed to question **10** ☐ Toviaz (fesoterodine) - Proceed to question **2** ☐ All others, including prescription Oxytrol - Proceed to question **6**	
2. Does the patient have a confirmed diagnosis of neurogenic detrusor overactivity (NDO)?	☐ Yes Proceed to question **3**	☐ No Proceed to question **6**
3. Is the patient 6 years of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient weigh more than 25 kg (55.1 lbs.)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a creatinine clearance (CrCl) less than 30 mL/min OR severe hepatic impairment (Child-Pugh Class C)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
6. Does the patient have a confirmed diagnosis of overactive bladder with symptoms of urge incontinence, urgency, and urinary frequency?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient had a trial of tolterodine extended-release (Detrol LA)**, oxybutynin IR, oxybutynin ER, or trospium immediate-release** (Sanctura immediate-release) **and experienced an inadequate response?**	☐ Yes **Sign and date below**	☐ No Proceed to question **8**
8. Has the patient had a trial of tolterodine extended-release (Detrol LA)**, oxybutynin IR, oxybutynin ER, or trospium immediate-release** (Sanctura immediate-release) **and experienced intolerable adverse effects?**	☐ Yes **Sign and date below**	☐ No Proceed to question **9**

9. Does the patient have a contraindication to tolterodine extended-release (Detrol LA)**, oxybutynin IR, oxybutynin ER, and trospium immediate-release** (Sanctura immediate-release) **which is not expected to occur with the requested medication?**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
10. "Oxytrol for Women" is the name of the over-the-counter (OTC) version of Oxytrol. This OTC medication is not covered under the USFHP pharmacy benefit. Please enter your initials in the text box to acknowledge that OTC Oxytrol for Women is not covered under the USFHP pharmacy benefit.	**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