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** (Vesicare)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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 **Which medication is being requested?**

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 Coverage not approved
2. 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 3
3. 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 4
4. 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 Coverage not approved

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

_____ _____

Prescriber Signature Date

[22 Jan 2014]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: