Prior Authorization Request Form for
vibegron **(Gemtesa)**

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 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 bladde (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

[30 November 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: