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

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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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. 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

[13 September 2021]

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