Prior Authorization Request Form for
mirabegron tablets **(Myrbetriq)**

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

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

USFHP Pharmacy Prior Authorization Form

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:

Question	Yes	No
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 Proceed to question **8**
2. Has the patient tried and failed behavioral interventions to include 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 bladder (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 Myrbetriq	________mL/min/1.73m2 Proceed to Question **7**	☐ 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 Myrbetriq	_________________ mg/dL or _______________mmols/L ________________ inches AND _________________lbs Proceed to Question **7**	
7. Is the provider aware that the dosage of Myrbetriq should not exceed 25 mg daily when the Crcl/ glomerular filtration rate (eGFR is between 15-29 mL//min/1.73m2?	☐ Yes **Sign and Date Below**	☐ No **STOP** **Coverage not approved**
8. Does the patient have a diagnosis of neurogenic detrusor overactivity (NDO) secondary to detrusor overactivity and/or myelomeningocele?	☐ Yes Proceed to Question **9**	☐ No **STOP** **Coverage not approved**
9. Is the medication being prescribed by or in consultation with a urologist or nephrologist?	☐ Yes Proceed to Question **10**	☐ No **STOP** **Coverage not approved**
10. Does the provider acknowledge 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?	☐ Acknowledged Proceed to question **11**	
11. 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?	☐ Acknowledged Proceed to question **12**	
12. Does the provider acknowledge that oxybutynin is available for patients with neurogenic detrusor overactivity and does not require prior authorization?	☐ Acknowledged Proceed to question **13**	
13. Has the patient tried and failed or had a contraindication to oxybutynin?	☐ Yes Proceed to Question **14**	☐ No **STOP** **Coverage not approved**
14. Does the patient weigh greater than or equal to 35 kg?	☐ 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

[30 November 2022]

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