Prior Authorization Request Form for
mirabegron (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:

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, 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 TWO of the following: tolterodine extended-release (Detrol LA), oxybutynin IR, oxybutynin ER, or trospium immediate-release (Sanctura immediate-release) and failed due to a treatment failure or intolerable adverse effects?	☐ 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 or other medications?	☐ Yes Proceed to question 5	☐ No **STOP** **Coverage not approved**
5. Is the patient's creatinine clearance (CrCl) LESS THAN 15 mL/min?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question 6

Continue on next page

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6. Is the patient's creatinine clearance (CrCl) GREATER THAN 29 mL/min?	☐ Yes **Sign and date below**	☐ No Proceed to question 7
7. Does the daily dose of the requested medication EXCEED 25 mg?	☐ Yes **STOP** **Coverage not approved**	☐ No **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

[02 August 2017]

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