EXPRESS SCRIPTS®

Prior Authorization Form
Overactive Bladder Step Therapy

This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.
Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-877-329-3760**
If this an **URGENT** request, please call 1-800-753-2851

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI **(required)**: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

- ☐ Detrol 1mg Tablet
- ☐ Detrol 2mg Tablet
- ☐ Detrol LA 2mg Extended-Release Capsule
- ☐ Detrol LA 4mg Extended-Release Capsule
- ☐ Ditropan 5mg/5ml Solution
- ☐ Ditropan 5mg Tablet
- ☐ Ditropan XL 5mg Extended-Release Tablet
- ☐ Ditropan XL 10mg Extended-Release Tablet
- ☐ Ditropan XL 15mg Extended-Release Tablet
- ☐ Myrbetriq
- ☐ Enablex 7.5mg Extended-Release Tablet
- ☐ Enablex 15mg Extended-Release Tablet
- ☐ Gelnique 10% Topical Gel
- ☐ Oxytrol 3.9mg/24hr Transdermal Patch
- ☐ Sanctura 20mg Tablet
- ☐ Sanctura XR 60mg Extended-Release Capsule
- ☐ Toviaz 4mg Extended-Release Tablet
- ☐ Toviaz 8mg Extended-Release Tablet
- ☐ Vesicare 5mg Tablet
- ☐ Vesicare 10mg Tablet

Directions for use (i.e. QD, BID, PRN & Qty):_____

Please complete the clinical assessment:			
1. Is the patient currently taking the requested medication?	☐ Yes	☐ No	☐ N/A
2. Is the patient taking samples or paying 100% out of pocket for the medication being requested? If no, please indicate: ☐ Requested medication covered under previous insurance plan ☐ Started medication in hospital ☐ Other: _____	☐ Yes	☐ No	☐ N/A

3. Has the patient tried oxybutynin IR (generic), oxybutynin ER (generic), trospium (generic), trospium XR (generic), tolterodine (generic), Enablex, Detrol, Detrol LA, Gelnique, Toviaz or Vesicare? If yes, please list: _____ _____	☐ Yes		☐ No
4. Is the patient unable to swallow or has difficulty swallowing?	☐ Yes	☐ No	☐ N/A

Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

_____

_____

_____

_____

_____

_____

_____

Prescriber Signature: _____Date: _____

Office Contact Name: _____ Phone Number: _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.