



**Over Active Bladder  
Long-Acting Anticholinergics  
Effective January 1, 2020**

<b>Plan</b>	<input type="checkbox"/> MassHealth <input checked="" type="checkbox"/> Commercial/Exchange	<b>Program Type</b>	<input type="checkbox"/> Prior Authorization
<b>Benefit</b>	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit (NLX)		<input type="checkbox"/> Quantity Limit <input checked="" type="checkbox"/> Step Therapy
<b>Specialty Limitations</b>	N/A		
<b>Contact Information</b>	<b>Specialty Medications</b>		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	<b>Non-Specialty Medications</b>		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
Exchange	Phone: 855-582-2022	Fax: 855-245-2134	
	<b>Medical Specialty Medications (NLX)</b>		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
<b>Exceptions</b>	N/A		

**Overview**

Prescriptions that meet the initial step therapy requirements will adjudicate automatically at the point of sale. If the prescription does not meet the initial step therapy requirements, the prescription will deny with a message indicating that prior authorization (PA) is required. Refer to the criteria below and submit a PA request for the members who do not meet the initial step therapy requirements at the point of sale.

Initial Step-Therapy Requirements:

**First-Line:** Medications listed on first-line are covered without prior-authorization.

**Second-Line:** Second-line medications will pay if the member has filled at least two different first-line medications or a second-line medication within the past 180 days.

**Coverage Guidelines**

If a member does not meet the initial step therapy requirements, then approval of a second-line medication will be granted if the member has had a documented inadequate response, side effect, or a contraindication to two different first-line medications.

FIRST-LINE	SECOND-LINE
Oxybutynin extended-release tablets Trospium chloride extended-release capsules	Darifenacin extended-release tablets Gelnique® (oxybutynin) gel Myrbetriq® extended-release (mirabegron) tablets Tolterodine extended-release capsules Toviaz® extended-release (fesoterodine) tablets VESIcare® (solifenacin) tablets



## References

1. Detrol LA (tolterodine) [prescribing information]. New York, NY: Pfizer; July 2018
2. Enablex (darifenacin) [prescribing information]. Irvine, CA: Allergan USA Inc; September 2016
3. Oxybutynin chloride tablets [prescribing information]. New Castle, DE: Marlex Pharmaceuticals Inc; March 2018
4. Gelnique 10% (oxybutynin chloride) gel [prescribing information]. Madison, NJ: Allergan USA Inc; March 2019
5. Myrbetriq (mirabegron) [prescribing information]. Northbrook, IL; Astellas Pharma; April 2018
6. Toviaz (fesoterodine) [prescribing information]. New York, NY: Pfizer Labs; November 2017
7. VESicare (solifenacin succinate) [prescribing information]. Northbrook, IL: Astellas Pharma US; February 2016
8. Lukacz ES. Treatment of urgency incontinence/overactive bladder in women. Post TW, ed. *UpToDate*. Waltham, MA: UpToDate Inc. Accessed March 8, 2019

## Review History

- 09/23/13 – Reviewed
- 11/04/13 – Implemented
- 09/22/14 – Reviewed
- 10/01/14 – Detrol LA generic
- 09/21/15 – Reviewed
- 09/19/16 – Reviewed
- 09/18/17 – Reviewed
- 09/24/18 – Updated Enablex to darifenacin ER
- 09/18/19 – Removed trial of trospium ER from clinical criteria
- 11/20/19 – Removed Oxytrol (non-formulary) and updated program to true ST (removed clinical criteria)

## Disclaimer

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