Pharmacy Medical Necessity Guidelines: 
Overactive Bladder Medications Step Therapy

Effective: July 10, 2018

<table>
<thead>
<tr>
<th>Prior Authorization Required</th>
<th>√</th>
<th>Type of Review – Care Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Covered</td>
<td></td>
<td>Type of Review – Clinical Review</td>
</tr>
<tr>
<td>Pharmacy (RX) or Medical (MED) Benefit</td>
<td>RX</td>
<td>Department to Review</td>
</tr>
</tbody>
</table>

This Pharmacy Medical Necessity Guideline applies to the following:

**Tufts Health Plan Commercial Plans**
- ✔ Tufts Health Plan Commercial Plans – large group plans
- ✔ Tufts Health Plan Commercial Plans – small group and individual plans

**Tufts Health Public Plans**
- ✔ Tufts Health Direct – Health Connector
- ☐ Tufts Health Together – A MassHealth Plan
- ☐ Tufts Health RITogether – A RIte Care + Rhody Health Partners Plan

**Tufts Health Freedom Plan products**
- ✔ Tufts Health Freedom Plan – large group plans
- ✔ Tufts Health Freedom Plan – small group plans

Fax Numbers:
- RXUM: 617.673.0988

**Note:** For Tufts Health Plan Medicare Preferred Members, please refer to the Tufts Health Plan Medicare Preferred Step Therapy Criteria. Background, applicable product and disclaimer information can be found on the last page.

**OVERVIEW**

Overactive bladder (OAB) is a form of urinary incontinence affecting both male and female patients of all ages. Signs and symptoms of OAB include urgency (defined as a sudden need to urinate), frequency (defined as emptying the bladder more than eight times per day), and nocturia with or without incontinence. The International Continence Society defines OAB as urgency, with or without urge incontinence, usually with frequency and nocturia. The prevalence of OAB increases with age and patients with a history of pelvic surgery, dementia, or diabetes may be at an increased risk of developing this condition.

Bladder contraction is primarily under control of the parasympathetic nervous system and anticholinergics are considered to be the pharmacologic treatment of choice for OAB. These agents work through the non-selective inhibition of acetylcholine on muscarinic receptors in smooth muscle throughout the body. Research suggests that the muscarinic3 (M3) receptor, located on bladder smooth muscle, is the predominate factor responsible for bladder contraction (i.e., these anticholinergics prevent unintentional bladder contraction). In addition, the M3 receptor mediates saliva production, gastrointestinal smooth muscle, and iris sphincter function; therefore, expected side effects of anticholinergics include dry mouth, constipation, and miosis. Some newer agents for OAB have a stronger affinity for the M3 receptor compared to other anticholinergic agents and therefore have comparable efficacy but a proposed lower side effect profile. The beta-3 adrenergic agonists have a novel mechanism of action and work by relaxing the detrusor smooth muscle during the storage phase of the urinary bladder fill-void cycle by activation of the beta-3 adrenergic receptor, which increases bladder capacity. The beta-3 adrenergic agonists offer an alternative treatment option for patients who cannot tolerate the adverse events from the anticholinergic agents. Myrbetriq (mirabegron) is the only beta-3 adrenergic agonists available, and flavoxate is the only urinary antispasmodic agent. All other available overactive bladder medications are anticholinergics.

**FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS**

Flavoxate is indicated for symptomatic relief of dysuria, urgency, nocturia, suprapubic pain, frequency and incontinence as may occur in cystitis, prostatitis, urethritis, and urethrocystitis/urethrotrigonitis.

Detrol (tolterodine), Detrol LA (tolterodine), Ditropan XL (oxybutynin), Enablex (darifenacin), Gelnique (oxybutynin), Myrbetriq (mirabegron), oxybutynin extended- and immediate-release, Sanctura (trospium), Sanctura XR (trospium), trospium extended- and immediate-release, tolterodine extended- and immediate-release, and Vesicare (solifenacin) are all indicated for the treatment of OAB with symptoms of urge urinary incontinence, urgency, and frequency.
Ditropan XL (oxybutynin) is also indicated for the treatment of pediatric patients aged six years and older with symptoms of detrusor overactivity associated with a neurological condition (e.g., spina bifida).

**COVERAGE GUIDELINES**

**Note:** Prescriptions that meet the initial step therapy requirements will adjudicate automatically at the point of service. If the Member does not meet the initial step therapy criteria, the prescription will deny at the point of service with a message indicating that prior authorization (PA) is required. Refer to the Coverage Criteria below and submit PA requests to the plan using the Universal Pharmacy Medical Review Request Form for Members who do not meet the step therapy criteria at the point of service.

Please refer to the table below for formularies and medications subject to this policy:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Tufts Health Plan Large Group Plans</th>
<th>Tufts Health Plan Small Group and Individual Plans</th>
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</thead>
<tbody>
<tr>
<td><strong>Step-1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>darifenacin</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>flavoxate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>oxybutynin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>oxybutynin ER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>tolterodine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>tolterodine ER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>trospium</td>
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</tr>
<tr>
<td>trospium ER</td>
<td></td>
<td></td>
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<tr>
<td>Vesicare®</td>
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<tr>
<td>Sanctura®</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sanctura® XR</td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>Ditropan® XL</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Step-2</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Detrol®</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detrol LA®</td>
<td>Requires prior use of a drug on Step-1 or Step-2</td>
<td>Not covered</td>
</tr>
<tr>
<td>Enablex®</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gelnique</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myrbetriq™</td>
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**Automated Step Therapy Coverage Criteria**

The following stepped approach applies to coverage of the Step-2 medications by the plan:

**Step 1:** Medications on Step-1 are covered without prior authorization.

**Step 2:** The plan may cover medications on Step-2 if the following criteria are met:
- The Member has had a trial of one (1) Step-1 or Step-2 medication within the previous 180 days as evidenced by a paid claim under the prescription benefit administered by the plan.

**Coverage Criteria for Members not meeting the Automated Step Therapy Coverage Criteria at the Point of Sale**

The following stepped approach applies to overactive bladder medications covered by the plan:

**Step 2:** The plan may cover Step-2 medications if the following criteria are met:
- The Member has had a trial of a Step-1 or Step-2 medication as evidenced by physician documented use, excluding the use of samples

**OR**

- Requesting physician has documented that the member has a contraindication to or is unable to tolerate medications on Step-1

**Note:** The plan may cover medications on Step-2 if a Member has received one of the non-covered medications, listed below under the limitations section, as evidenced by physician documented use, excluding the use of samples.
LIMITATIONS
1. Previous use of samples or vouchers/coupons for brand name medications will not be considered for authorization.
2. The plan does not cover the following medications on all Commercial formularies: Toviaz® (fesoterodine) and Oxytrol®. Please refer to the Pharmacy Medical Necessity Guidelines for Non-Covered Drugs with Suggested Alternatives and submit a formulary exception request to the plan as indicated.
3. The plan does not cover the following brand name medications on the MA/RI Exchange formularies: Ditropan XL, Detrol, Detrol LA, Enablex, Sanctura, and Sanctura XR. Please refer to the Pharmacy Medical Necessity Guidelines for Non-Covered Drugs with Suggested Alternatives and submit a formulary exception request to the plan as indicated.

CODES
None

REFERENCES

APPROVAL HISTORY
November 11, 2009: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
- January 1, 2010: Removal of Tufts Health Plan Medicare Preferred language (separate criteria have been created specifically for Tufts Health Plan Medicare Preferred).
- September 13, 2011: Added historical look back period of 2 years for physician documented use of Step Therapy pre-requisite drugs
- January 10, 2012: No changes
- June 12, 2012: Administrative update: removed historical look back period of 2 years for physician documented use of Step Therapy pre-requisite drugs. Clarified step criteria to reflect that Step-2 drugs are prerequisites for drugs on Step-2.
- August 14, 2012: Added generic tolterodine tablets to Step-1 of step therapy program. Added non-covered Toviaz (fesoterodine) as a prerequisite drug. Added use of samples or vouchers/coupons for brand name medications limitation.
- February 12, 2013: Changed the title of the Medical Necessity Guideline from Detrol (tolterodine) and Detrol LA (tolterodine tartrate ext-rel) to Overactive Bladder Medications Step Therapy. Added Myrbetriq (mirabegron) to Step-2 of the Medical Necessity Guidelines and updated the FDA-Approved indications to include information on Myrbetriq (mirabegron).
- October 8, 2013: Administrative update: Removed requirement of 30-day trial and replaced with just a previous trial of the medication.
- February 11, 2014: Added tolterodine ext-rel to Step-1 and moved Detrol and Detrol LA to Not Covered for the GFF.
- April 1, 2014: Administrative Update: Removed language pertaining to the Generic Focused Formulary and added the EHB MA/RI Formulary.
- January 13, 2015: Removed Oxytrol from the medical necessity guidelines as it has been moved to Non-covered effective 1/1/15.
- March 10, 2015: For effective date April 1, 2015: Moved Ditropan XL, Detrol, Detrol LA, Sanctura, and Sanctura XR to not covered for the MA/RI EHB formularies.
- January 1, 2016: Administrative change to rebranded template applicable to Tufts Health Direct.
- March 8, 2016: No changes
- April 12, 2016: Added generic darifenacin to Step-1. Moved Enablex to Step-2 to for Large group formularies and to not covered for the MA/RI EHB formularies.
- April 11, 2017: Administrative update, Adding Tufts Health RITogether to the template.
May 8, 2018: Updated the coverage criteria to clarify that request for Step-2 medications may be approved if the requesting physician has documented that the member has a contraindication to or is unable to tolerate medications on Step-1.

**BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION**

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a Member’s benefit document and in coordination with the Member’s physician(s). The plan makes coverage decisions on a case-by-case basis considering the individual Member’s health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan Members or to certain delegated service arrangements. Unless otherwise noted in the Member's benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLinkSM Members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence.

For Tufts Health Plan Medicare Preferred, please refer to Tufts Health Plan Medicare Preferred Prior Authorization Criteria.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to Member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.