

Overactive Bladder Agents Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information <small>(required)</small>					
Select the requested drug below:					
<input type="checkbox"/> Enablex (darifenacin ER)		<input type="checkbox"/> Myrbetriq		<input type="checkbox"/> Toviaz	
<input type="checkbox"/> Gelnique		<input type="checkbox"/> Oxytrol		<input type="checkbox"/> Vesicare	
<input type="checkbox"/> Gelnique pump					
What is the patient's diagnosis for the medication being requested? _____					
ICD-10 Code(s): _____					
Clinical information:					
Was the patient initiated on therapy with requested medication while covered under another insurance plan and converted to Sentara/Optima coverage within the last <u>60 days</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select if the patient has documentation of at least a 30-day trial and failure of the following medications:					
<input type="checkbox"/> Oxybutynin					
<input type="checkbox"/> Oxybutynin extended-release (ER)					
<input type="checkbox"/> Oxytrol for Women					
<input type="checkbox"/> Tolterodine					
<input type="checkbox"/> Tolterodine ER					
<input type="checkbox"/> Trospium					
<input type="checkbox"/> Trospium ER					
Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.					
Previous therapies will be verified through pharmacy paid claims or submitted chart notes.					
Prescriber Signature: _____			Date: _____		

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

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.