Clinical Pharmacy Program Guidelines for Overactive Bladder Agents - ARIZONA

<table>
<thead>
<tr>
<th>Program</th>
<th>Step Therapy</th>
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<tbody>
<tr>
<td>Medication</td>
<td>Preferred: oxybutynin syrup, oxybutynin tablet, oxybutynin extended-release tablet, Oxytrol for Women (oxybutynin OTC) patch</td>
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<tr>
<td></td>
<td>Preferred with Step Therapy: tolterodine tablet, trospium tablet, Detrol LA (tolterodine) extended-release capsule</td>
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<td>Non-Preferred:</td>
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<tr>
<td></td>
<td>Oxytrol (oxybutynin Rx) patch, flavoxate tablet, trospium extended-release capsule, Enablex (darifenacin) extended-release tablet, Toviaz (fesoterodine) extended release tablet, Vesicare (solifenacin) tablet, Myrbetriq (mirabegron) extended-release tablet, Gelnique (oxybutynin) topical gel, Ditropan XL (oxybutynin) extended-release tablet, Detrol (tolterodine) tablet</td>
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1. **Background:**

Trospium and tolterodine are indicated for the treatment of OAB with symptoms of urge urinary incontinence, urgency, and frequency.

Oxybutynin is indicated for the relief of symptoms of bladder instability associated with voiding in patients with uninhibited neurogenic or reflex neurogenic bladder (i.e., urgency, frequency, urinary leakage, urge incontinence, dysuria).

2. **Coverage Criteria:**

1. **Preferred Product Requests**

   1. Tolterodine IR or trospium will be approved for patients when **one** of the following circumstances is met:

      a. The patient did not exhibit an adequate response to treatment with oxybutynin

      - OR -

      b. The patient experienced an intolerance/adverse reaction to previous therapy with oxybutynin

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2. Tolterodine extended-release capsule will be approved for patients when one of the following circumstances is met:

   a. The patient did not exhibit an adequate response to treatment with oxybutynin and tolterodine

   -OR-

   b. The patient experienced an intolerance/adverse reaction to previous therapy with oxybutynin and tolterodine

   -OR-

   c. The patient has a documented contraindication to treatment with oxybutynin and tolterodine

   -OR-

   d. The patient is greater than or equal to 65 years of age.

C. Non-Preferred Requests

   1. Oxytrol (oxybutynin Rx) patch, trospium extended-release capsule, Enablex (darifenacin) extended-release tablet, Toviaz (fesoterodine) extended release tablet, Vesicare (solifenacin) tablet, Myrbetriq (mirabegron) extended-release tablet, Gelnique (oxybutynin) topical gel, Ditropan XL (oxybutynin) extended-release tablet, Detrol (tolterodine) tablet will be approved based on the following:

      a. The patient has a history of failure, contraindication, or intolerance to a trial of at least three preferred products, one of which MUST be oxybutynin extended release tablet
2. Flavoxate will be approved based on the following

   a. The patient has a history of failure, contraindication, or intolerance to a trial of at least three preferred products

   **Authorization will be issued for 12 months.**

3. **Additional Clinical Rules:**
   - Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
   - Supply limits may be in place.

4. **References:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Change</th>
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<tbody>
<tr>
<td>August 2017</td>
<td>New policy specific to Arizona.</td>
</tr>
<tr>
<td>September 2018</td>
<td>Annual review, updated background and references.</td>
</tr>
<tr>
<td>November 2019</td>
<td>Updated background and references. Updated criteria for non-preferred products.</td>
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