MASSACHUSETTS

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Pharmacy Medical Policy
Overactive Bladder Medications

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Policy Number: 170

BCBSA Reference Number: None

Related Policies

- Quality Care Dosing guidelines apply to the following medications and can be found in Medical Policy #621A

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Note: All requests for outpatient retail pharmacy for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the Prior Authorization Form on the last page of this document. Physicians may also call BCBSMA Pharmacy Operations department at (800)366-7778 to request a prior authorization/formulary exception verbally. Patients must have pharmacy benefits under their subscriber certificates.

Please refer to the chart below for the formulary and step status of the medications affected by this policy.

Drug	Formulary Information Standard Formulary Status
STEP 1	
darifenacin ER	Covered
oxybutynin	
oxybutynin ER	
solifenacin	
tolterodine	
tolterodine ER	
trospium	
trospium XR	

STEP 2	
Myrbetriq ™ (mirabegron)	Prior use of Step 1 Required
Gemtesa ®(vibegron)	
STEP 3	
Detrol ®** (tolterodine)	Prior use of Step 1 and Step 2 Required
Detrol ®**LA** ** (tolterodine)	
Ditropan ® ** (oxybutynin)	
Ditropan ® **XL** ** (oxybutynin)	
Enablex ®** (darifenacin)	
Gelnique ®** (oxybutynin)	
Oxytrol ®**## (oxybutynin)	
Toviaz ™** (fesoterodine fumarate)	
VESIcare ® (solifenacin succinate)	

**Non-formulary medications are covered when a formulary exception request is submitted to BCBSMA Pharmacy Operations and criteria below are met.

By benefit design [contract] Oxytrol® OTC Patch is excluded from coverage as it is available without a prescription

Policy

Commercial Members

We cover the Overactive bladder medications listed in the chart above for new starts* in the following stepped approach [A].

*New start is defined as no previous paid claim for the requested medication within the past 130 days.

Step 1: Step 1 medications will be covered without prior authorization.

Step 2: Step 2 medication may be covered when the following criterion is met:

- There must be evidence of a BCBSMA paid claim by the patient of a step one medication within the previous 130 days,

OR

- There must be evidence of a BCBSMA paid claim by the patient of a step 2 medication within the previous 130 days.

Step 3: Step 3 medications may be covered when **one** of the following criteria are met:

- There must be evidence of a BCBSMA paid claim by the patient of both a step 1 and a step 2 medication within the previous 130 days.

OR

- There must be evidence of a BCBSMA paid claim of the requested step 3 drug within the previous 130 days.

**Exception requests based exclusively on the use of samples will not meet coverage criteria for non-formulary medications. Additional clinical information demonstrating medical necessity of the non-formulary medication must be submitted by the requesting prescriber for review.
We do not cover drugs listed in the above chart unless the above step therapy criteria are met.

Individual Consideration

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. Physicians may send relevant clinical information for individual patients for consideration to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-800-583-6289

Prior Authorization Information

Outpatient

For services described in this policy, see below for products where prior authorization **IS REQUIRED** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **required**.
Commercial PPO	Prior authorization is **required**.

Policy History

Date	Action
4/2021	Update to add Gemtesa to step 2.
1/2021	Update to add Vesicare to step 3.
9/2019	Updated to revise Step Criteria.
7/2019	Updated to add Solifenacin to step 1.
10/2017	Updated to add Myrbetriq™ to Step2 of Policy.
6/2017	Updated address for Pharmacy Operations.
10/2016	Added Darifenacin ER to step 1 and removed gender reference.
3/2014	Added Tolterodine ER to step 1.
1/2014	Updated to limit Oxytrol ® prescription coverage to males because an FDA approved product, Oxytrol ® for Women is available for females without a prescription. Updated ExpressPAth language and remove Blue Value.
3/2013	Updated to include coverage for new FDA approved medications tolterodine, trospium and trospium XR.
9/2012	Updated to include coverage for new FDA approved medication Myrbetriq™
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
1/2012	Updated to include Gelnique® and Oxytrol® as Step 3 medications.
9/2011	Reviewed - Medical Policy Group - Urology and Obstetrics/Gynecology. No changes to policy statements.
6/2010	Reviewed - Medical Policy Group - Urology and Obstetrics/Gynecology. No changes to policy statements.
1/1/2010	New policy, effective 1/1/2010, describing covered and non-covered indications.

References

1. Detrol® LA [package insert]. New York, NY: Pfizer Labs; August 2012.
2. Ditropan® XL [package insert]. Vacaville, CA: Alza Corporation; 2009.
3. Enablex® [package insert]. Cincinnati, Ohio: Procter & Gamble Pharmaceuticals; 2008.
4. Sanctura® XR [package insert]. Irvine, CA: Alelrgan, Inc.; 2007.
5. Sanctura® [package insert]. Irvine, CA: Alelrgan, Inc.; July 2012.
6. Toviaz™ [package insert]. New York, NY: Pfizer Labs; 2008.
7. VESIcare [package insert]. Deerfield, IL: Astellas Pharma Technologies; 2008.
8. Gelnique® [package insert].Morristown, NJ: Watson Pharma, Inc., 2011.

9. Oxytrol® [package insert]. Morristown, NJ: Watson Pharma, Inc., 2010.
10. Myrbetriq™ [package insert]. Northbrook, IL: Astellas Pharma Technologies; 2012.
11. Oxytrol® for Women [Product Brochure]. MSD Consumer Care, 2013
12. Gemtesa® [package insert]. Irvine, CA: Urovant Sciences, Inc.; Jan 2021.

Endnotes

A. Based on the recommendations of the BCBSMA Pharmacy and Therapeutics Committee meeting on 9/15/2009.

To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:

http://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf