Clinical Policy: Overactive Bladder Agents

Reference Number: IL.PMN.198
Effective Date: 1.1.20
Last Review Date: 9.9.22 Revision Log
Line of Business: Medicaid

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Description

The following are overactive bladder agents requiring prior authorization: mirabegron (Myrbetriq®, Myrbetriq® Granules), fesoterodine (Toviaz®), solifenacin (Vesicare®, Vesicare LS™), and darifenacin (Enablex®).

FDA Approved Indication(s)

Myrbetriq, Toviaz, Vesicare, and Enablex are indicated for the treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency. Vesicare is specifically indicated for adults.

Myrbetriq, Myrbetriq Granules, Toviaz and Vesicare LS are indicated for the treatment of neurogenic detrusor overactivity in pediatric patients:

- Aged 3 years and older and weighing 35 kg or more (Myrbetriq);
- Aged 3 years and older (Myrbetriq Granules);
- Aged 6 years and older and weighing greater than 25 kg (Toviaz);
- Aged 2 years and older (Vesicare LS).

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that overactive bladder agents are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Overactive Bladder (must meet all)**:**

1. Diagnosis of overactive bladder;
   a. Member has neurogenic detrusor overactivity, and request is for one of the following (i, ii, or iii):
      i. Vesicare LS, and age is between 2 to 17 years;
      ii. Myrbetriq Granules, and age is between 3 to 17 years;
      iii. Myrbetriq, age is between 3 to 17 years, and member weighs at least 35 kg;
      iv. Toviaz, age is between 6 to 17 years, and member weights at least 25 kg;
   b. Age ≥ 18 years;

2. Failure of 2 formulary generic overactive bladder agents (e.g., oxybutynin, bethanechol, and solifenacin) each used for 30 days, unless contraindicated or clinically significant adverse effects are experienced;
3. If request is for Vesicare LS and age ≥ 18 years: Medical justification supports inability to use oral solifenacin (e.g., contraindications to excipients, inability to swallow);
4. Dose does not exceed the FDA-approved maximum recommended dose for the relevant drug.

Approval duration:
Medicaid – 12 months

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Overactive Bladder (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for Vesicare LS and age ≥ 18 years: Medical justification supports continued inability to use oral solifenacin (e.g., contraindications to excipients, inability to swallow);
4. If request is for a dose increase, new dose does not exceed the FDA-approved maximum recommended dose for the relevant drug or health plan approved quantity limit for the relevant drug.

Approval duration:
Medicaid – 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off-label use policy – CP.PMN.53 for Medicaid.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

Appendix B: Contraindications/Boxed Warnings

- Contraindication(s):
  - Hypersensitivity to any component in the requested product
  - Enablex, Toviaz, and Vesicare are also contraindicated in patients with, or at risk for, the following conditions:
    - Urinary retention
    - Gastric retention
    - Uncontrolled narrow-angle glaucoma
  -
- Boxed warning(s): none reported

V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Fesoterodine (Toviaz)	*Pediatric patients*: > 25 kg to ≤ 35 kg: Recommended dose is 4 mg PO QD. If needed, dosage may be increased to 8 mg PO QD. > 35 kg: Recommended starting dose is 4 mg PO QD. After one week, increase to 8 mg PO QD. *Adults*: 4 mg PO QD4 mg PO QD	8 mg/day
Mirabegron (Myrbetriq)	25 mg PO QD; can be given alone for either indication or in combination with solifenacin succinate 5 mg PO QD for OAB	50 mg/day
Mirabegron (Myrbetriq Granules)*	*Pediatric patients*: 11 to < 22 kg: 3 mL (24 mg) PO QD 22 to < 35 kg: 4 mL (32 mg) PO QD ≥ 35 kg: 6 mL (48 mg) PO QD *Adults*: A recommended dosage for Myrbetriq Granules for adults has not been determined.	11 to < 22 kg: 6 mL (48 mg)/day 22 to < 35 kg: 8 mL (64 mg)/day ≥ 35 kg: 10 mL (80 mg)/day
Solifenacin (Vesicare)	5 mg PO QD	10 mg/day
Solifenacin (Vesicare LS)	9-15 kg: 2 mL PO QD > 15-30 kg: 3 mL PO QD > 30-45 kg: 3 mL PO QD > 45-60 kg: 4 mL PO QD > 60 kg: 5 mL PO QD	9-15 kg: 4 mL > 15-30 kg: 5 mL > 30-45 kg: 6 mL > 45-60 kg: 8 mL > 60 kg: 10 mL

Drug Name	Dosing Regimen	Maximum Dose
	After administration of the recommended starting dose, the dose may be increased to the lowest effective dose but should not exceed the maximum recommended dose	
Darifenacin (Enablex)	7.5 mg PO QD	15 mg/day

VI. Product Availability

Drug Name	Availability
Fesoterodine (Toviaz)	Extended-release tablets: 4 mg, 8 mg
Mirabegron (Myrbetriq)	Extended-release tablets: 25 mg, 50 mg
Mirabegron (Myrbetriq Granules)	Granules for extended-release oral suspension: 8 mg/mL after reconstitution
Solifenacin (Vesicare)	Tablets: 5 mg, 10 mg
Solifenacin (Vesicare LS)	Oral suspension: 5 mg/5 mL (1 mg/mL)
Darifenacin (Enablex)	Extended-release tablets: 7.5 mg, 15 mg

VII. References

1. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2020. Available at: http://www.clinicalpharmacology-ip.com. Accessed February 21, 2022 .
2. Myrbetriq and Myrbetriq Granules Prescribing Information. Northbrook, IL: Astellas Pharma US, Inc.; March 2021. Available at: https://www.myrbetriq.com. Accessed February 21, 2022.
3. Vesicare Prescribing Information. Northbrook, IL: Astellas Pharma US, Inc.; May 2020. Available at: https://www.vesicare.com. Accessed February 21, 2022.
4. Vesicare LS Prescribing Information. Northbrook, IL: Astellas Pharma US, Inc.; May 2020. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2020/209529s000lbl.pdf. Accessed January 15, 2021.
5. Toviaz Prescribing Information. New York, NY: Pfizer Inc.; July 2021. Available at: http://www.toviaz.com. Accessed February 21, 2022.
6. Gormley EA, Lightner DJ, Burgio KL, et al. Diagnosis and treatment of overactive bladder (non-neurogenic) in adults: AUA/SUFU guideline (2019). Available at: https://www.auanet.org/guidelines/overactive-bladder-(oab)-guideline. Accessed January 15, 2021.
7. Enablex Prescribing Information. Irvine, CA: Allergan; September 2016. Available at: http://www.enablex.com. Accessed February 21, 2022.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created, adapted CP.PMN.198 Overactive Bladder Agents policy.	12.17.19	1.7.20

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2021 annual review. No significant changes. Reference updated.	12.28.20	
Added Vesicare LS with corresponding criteria; added If request is for Vesicare LS and age ≥ 18 years: Medical justification supports inability to use oral solifenacin	1.25.21	
2Q 2021 Annual Review: updated FDA indication; added Myrbetriq Granules and new indication for pediatric neurogenic detrusor overactivitiy; updated table for product availability; updated contraindication; updated tablet dosage and administration; reviewed and updated references	6.25.21	
RT4: added Toviaz's pediatric extension of the overactive bladder indication.	9.2.21	
3Q2022 annual review: no significant changes, references reviewed and updated	9.9.22	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan

retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.
Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the non-formulary policy; HIM.PA.103.