Mass General Brigham
Health Plan

Overactive Bladder Medications
Effective 11/01/2025

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☐ Prior Authorization ☐ Quantity Limit ☒ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693 **Non-Specialty Medications** All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	N/A		

Overview
Prescriptions that meet the initial step therapy requirements will adjudicate automatically at the point of sale. If the prescription does not meet the initial step therapy requirements, the prescription will deny with a message indicating that prior authorization (PA) is required. Refer to the criteria below and submit a PA request for the members who do not meet the initial step therapy requirements at the point of sale.

Initial Step-Therapy Requirements:
First-Line: Medications listed on first-line are covered without prior-authorization.
Second-Line: Second-line medications will pay if the member has filled at least ONE first-line medication or a second-line medication within the past 180 days.

Coverage Guidelines
Authorization may be granted for members new to the plan within the last 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs
OR
If a member does not meet the initial step therapy requirements, then approval of a second-line medication will be granted if the member has had an inadequate response, side effect, or a contraindication to one first-line or one second-line medication.

FIRST-LINE	SECOND-LINE
Oxybutynin extended-release tablets Solifenacin tablets Trospium chloride extended-release capsules	Darifenacin extended-release tablets Fesoterodine extended-release tablet Mirabegron extended-release tablet Tolterodine extended-release capsules

Limitations
1. Approvals will be granted for 12 months

References

1. Balk EM, Rofeberg VN, Adam GP, et al. Pharmacologic and Nonpharmacologic Treatments for Urinary Incontinence in Women: A Systematic Review and Network Meta-analysis of Clinical Outcomes. Ann Intern Med 2019; 170:465.
2. Detrol LA (tolterodine) [prescribing information]. New York, NY: Pfizer; July 2018.
3. Enablex (darifenacin) [prescribing information]. Irvine, CA: Allergan USA Inc; July 2021.
4. Franco I, Hoebeke P, Baka-Ostrowska M, et al. Long-term efficacy and safety of solifenacin in pediatric patients aged 6 months to 18 years with neurogenic detrusor overactivity: results from two phase 3 prospective open-label studies. *J Pediatr Urol*. 2020;16(2):180.e1-180.e8.
5. Gelnique 10% (oxybutynin chloride) gel [prescribing information]. Madison, NJ: Allergan USA Inc; March 2019.
6. Lukacz ES. Urgency incontinence/overactive bladder in women: treatment. Brubaker L, Schmader E, eds. *UpToDate*. Waltham, MA: UpToDate Inc. Accessed June 27, 2024.
7. Mirabegron extended-release tablet [prescribing information]. Baltimore, MD: Lupin Pharmaceuticals, Inc.; April 2024.
8. Myrbetriq (mirabegron extended-release) tablet, granule [prescribing information]. Northbrook, IL; Astellas Pharma; April 2021.
9. Oxybutynin chloride extended-release tablet [prescribing information]. Fort Lee, NJ: Drug Ocean, LLC; October 2023.
10. Toviaz (fesoterodine) [prescribing information]. New York, NY: Pfizer; February 2024.
11. Vesicare (solifenacin succinate) [prescribing information]. Northbrook, IL: Astellas Pharma US; October 2022.

Review History

09/23/13 – Reviewed
11/04/13 – Implemented
09/22/14 – Reviewed
10/01/14 – Detrol LA generic
09/21/15 – Reviewed
09/19/16 – Reviewed
09/18/17 – Reviewed
09/24/18 – Updated Enablex to darifenacin ER
09/18/19 – Removed trial of trospium ER from clinical criteria
11/20/19 – Removed Oxytrol (non-formulary) and updated program to true ST (removed clinical criteria)
09/16/2020 – Updated and Reviewed Sept P&T Mtg; Moved solifenacin (generic Vesicare) to first line agent. Vesicare (generic) launched and removed from criteria and formulary. Effective 11/01/20.
11/17/2021 – Updated and reviewed for Nov P&T; Added new formulation of Myrbetriq oral granules as second line agent. Effective 02/01/2022.
07/20/2022 – Updated and reviewed for July P&T; Fesoterodine extended-release released and added as second line agent. Brand Toviaz moved to non-formulary. Effective 10/1/2022
11/16/2022 – Updated and reviewed for Nov P&T; Myrbetriq and Gelnique removed from second line agents and move to non-formulary. Added Gemtesa as a second line agent. Effective 01/01/2023.
07/10/2024 – Updated and reviewed for July P&T; Gemtesa removed from second-line agents and moved to non-formulary status; Added mirabegron extended-release tablet as a second-line agent; Added step therapy language to the criteria; Effective 10/01/2024.
08/14/2024 – Reviewed and updated for August P&T; Updated approval criteria to match step therapy edit; Clarified approval length is 12 months; Effective 10/01/2024.

08/13/2025 – Reviewed and updated at August P&T. Removed documentation requirement from criteria. Effective 11/01/2025.