Clinical Policy: Overactive Bladder Agents

Reference Number: CP.PMN.198
Effective Date: 05.01.16
Last Review Date: 05.25
Line of Business: Commercial, HIM, Medicaid Revision Log

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™), darifenacin, and vibegron (Gemtesa®).

FDA Approved Indication(s)

Gemtesa, Myrbetriq, Toviaz, Vesicare, and darifenacin are indicated for the treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency. Gemtesa, Myrbetriq, Toviaz, and Vesicare are specifically indicated for adults. Gemtesa is additionally indicated in adult males on pharmacological therapy for benign prostatic hyperplasia (BPH).

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, including neurogenic detrusor overactivity;
2. Member meets one of the following (a or b):
   a. Age ≥ 18 years;
   b. Member has neurogenic detrusor overactivity, and request is for one of the following (i, ii, iii, or iv):
      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;

3. Failure of 2 formulary generic overactive bladder agents (e.g., tolterodine, oxybutynin, trospium) for 30 days, unless clinically significant adverse effects are experienced or all are contraindicated;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395.*
4. If request is for brand Vesicare: Member must use the generic version of the requested product, unless contraindicated or clinically significant adverse effects are experienced;
5. If request is for Vesicare LS and age ≥ 18 years: Member must use generic solifenacin tablet, unless contraindicated or clinically significant adverse effects are experienced;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395.*
6. If request is for Toviaz, member must use generic fesoterodine, unless contraindicated or clinically significant adverse effects are experienced;
7. If request is for brand Myrbetriq, member must use generic mirabegron, unless contraindicated or clinically significant adverse effects are experienced;
8. Dose does not exceed the FDA-approved maximum recommended dose or health plan approved quantity limit for the relevant drug.

Approval duration: 12 months

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

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

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;

b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*

2. Member is responding positively to therapy;
3. If request is for brand Vesicare: Member must use the generic version of the requested product, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for Vesicare LS and age ≥ 18 years: Member must use generic solifenacin tablet, unless contraindicated or clinically significant adverse effects are experienced;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395.*
5. If request is for Toviaz, member must use generic fesoterodine, unless contraindicated or clinically significant adverse effects are experienced;
6. If request is for brand Myrbetriq, member must use generic mirabegron, unless contraindicated or clinically significant adverse effects are experienced;
7. If request is for a dose increase, new dose does not exceed the FDA-approved maximum recommended dose or health plan approved quantity limit for the relevant drug.

Approval duration: 12 months

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and 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.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
oxybutynin (Ditropan XL®)	5 to 10 mg PO QD	30 mg/day
oxybutynin (Ditropan®)	5 mg PO BID or TID	20 mg/day
tolterodine IR (Detrol®)	2 mg PO BID	4 mg/day
trospium (Sanctura®)	20 mg PO BID	60 mg/day
trospium ER (Sanctura® XR)	60 mg PO QD	60 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Gemtesa, Myrbetriq, Myrbetriq Granules, Toviaz, Vesicare, Vesicare LS: Hypersensitivity to any component in the requested product
  - Darifenacin, Toviaz, Vesicare, and Vesicare LS are also contraindicated in patients with, or at risk for, the following conditions:
    - Urinary retention (except Vesicare LS)
    - 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 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	11 to < 22 kg: 6 mL (48 mg)/day

Drug Name	Dosing Regimen	Maximum Dose
	≥ 35 kg: 6 mL (48 mg) PO QD *Adults*: A recommended dosage for Myrbetriq Granules for adults has not been determined.	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 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	9-15 kg: 4 mL > 15-30 kg: 5 mL > 30-45 kg: 6 mL > 45-60 kg: 8 mL > 60 kg: 10 mL
Darifenacin	7.5 mg PO QD	15 mg/day
Vibegron (Gemtesa)	75 mg PO QD	75 mg/day

**Myrbetriq and Myrbetriq Granules are two different products, and they are not substitutable on a milligram-per-milligram basis. Do not combine Myrbetriq and Myrbetriq Granules to achieve the total dose.*

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	Extended-release tablets: 7.5 mg, 15 mg
Vibegron (Gemtesa)	Tablets: 75 mg

VII. References

1. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2024. Available at: https://www.clinicalkey.com. Accessed February 24, 2025.
2. Myrbetriq and Myrbetriq Granules Prescribing Information. Northbrook, IL: Astellas Pharma US, Inc.; April 2021. Available at: https://www.myrbetriq.com. Accessed February 24, 2025.
3. Vesicare Prescribing Information. Northbrook, IL: Astellas Pharma US, Inc.; October 2022. Available at: https://www.astellas.com/us/system/files/254285-ves_pi_26may2020_0.pdf. Accessed February 24, 2025.
4. Vesicare LS Prescribing Information. Northbrook, IL: Astellas Pharma US, Inc.; October 2022. Available at: https://www.astellas.com/us/system/files/246252-ves_pi_26may2020.pdf. Accessed February 24, 2025.

5. Toviaz Prescribing Information. New York, NY: Pfizer Inc.; February 2024. Available at: https://www.pfizer.com/products/product-detail/toviaz. Accessed February 24, 2025.
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 February 24, 2025.
7. Gemtesa Prescribing Information. Irvine, CA: Urovant Sciences, Inc.; December 2024. Available at: www.gemtesa.com. Accessed February 24, 2025.
8. Darifenacin Prescribing Information. Princeton, NJ: Macleods Pharma USA, Inc.; January 2023. Available at: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=7ae60119-e22c-4806-a5d8-db7c9e8984a2. Accessed February 24, 2025.
9. Cameron AP, Chung DE, Dielubanza EJ, et al. The AUA/SUFU guideline on the diagnosis and treatment of idiopathic overactive bladder. Neurourol Urodyn. 2024 Nov; 43(8): 1742-1752.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added requirement for medical justification for inability to use generic for requests for brand Vesicare or Enablex®; removed HIM-specific notations regarding Enablex (can now use of this policy instead of HIM.PA.103); added requirement that request does not exceed health plan approved quantity limit; RT4: specified Vesicare is only indicated for adults per updated FDA labeling and added Vesicare LS with corresponding criteria.	05.28.20	08.20
Per December SDC and prior clinical guidance, added Commercial line of business.	12.15.20	
2Q 2021 annual review: RT4: added Myrbetriq Granules and new indication for pediatric neurogenic detrusor overactivitiy; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	01.15.21	05.21
RT4: added Toviaz's pediatric extension of the overactive bladder indication.	07.21.21	
2Q 2022 annual review: no significant changes; modified medical justification language to instead state "member must use"; for solifenacin redirection modified from "oral solifencin" to "generic solifenacin tablet" for added clarity; clarified contraindications by product in Appendix C; references reviewed and updated.	02.21.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.05.22	
2Q 2023 annual review: for Toviaz requests added generic redirection; references reviewed and updated.	01.10.23	05.23
Added Gemtesa to policy.	09.19.23	11.23

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2024 annual review: no significant changes; removed references to Enablex as branded product was discontinued; references reviewed and updated.	01.10.24	05.24
RT4: for Gemtesa added additional indication for overactive bladder in adult males on pharmacological therapy for benign prostatic hyperplasia per updated prescribing information.	01.13.25	
2Q 2025 annual review: for brand Myrbetriq, added redirection to generic mirabegron; references reviewed and updated. Added step therapy bypass for IL HIM per IL HB 5395.	01.28.25	05.25

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.