Urinary Incontinence Quantity Limit Program Summary

Quantity limits apply to Medicaid.

POLICY REVIEW CYCLE

Effective Date	Date of Origin
10/1/2023	10/1/2008

FDA APPROVED INDICATIONS AND DOSAGE

See package insert for FDA prescribing information: https://dailymed.nlm.nih.gov/dailymed/index.cfm

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
	darifenacin hydrobromide tab er	15 MG ; 7.5 MG	30	Tablets	30	DAYS			
	oxybutynin chloride solution	5 MG/5ML	600	mLs	30	DAYS			
	oxybutynin chloride syrup	5 MG/5ML	600	mLs	30	DAYS			
	oxybutynin chloride tab	2.5 MG	90	Tablets	30	DAYS			
	Oxybutynin Chloride Tab 5 MG	5 MG	120	Tablets	30	DAYS			
	Oxybutynin Chloride Tab ER 24HR 15 MG	15 MG	60	Tablets	30	DAYS			
	trospium chloride cap er	60 MG	30	Capsules	30	DAYS			
	trospium chloride tab	20 MG	60	Tablets	30	DAYS			
Detrol	tolterodine tartrate tab	1 MG ; 2 MG	60	Tablets	30	DAYS			
Detrol la	tolterodine tartrate cap er	2 MG ; 4 MG	30	Capsules	30	DAYS			
Ditropan xl	Oxybutynin Chloride Tab ER 24HR 10 MG	10 MG	60	Tablets	30	DAYS			
Ditropan xl	Oxybutynin Chloride Tab ER 24HR 5 MG	5 MG	30	Tablets	30	DAYS			
Gelnique	oxybutynin chloride td gel	10 %	30	Sachets	30	DAYS			
Gemtesa	vibegron tab	75 MG	30	Tablets	30	DAYS			
Myrbetriq	mirabegron granules for oral extended release susp	8 MG/ML	300	mLs	28	DAYS			

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Myrbetriq	mirabegron tab er	25 MG ; 50 MG	30	Tablets	30	DAYS			
Oxytrol ; Oxytrol for women	oxybutynin td patch twice weekly	3.9 MG/24HR	8	Patches	28	DAYS			
Toviaz	fesoterodine fumarate tab er	4 MG ; 8 MG	30	Tablets	30	DAYS			
Vesicare	solifenacin succinate tab	10 MG ; 5 MG	30	Tablets	30	DAYS			
Vesicare ls	solifenacin succinate susp	5 MG/5ML	300	mLs	30	DAYS			

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
	darifenacin hydrobromide tab er	15 MG ; 7.5 MG	Medicaid
	oxybutynin chloride solution	5 MG/5ML	Medicaid
	oxybutynin chloride syrup	5 MG/5ML	Medicaid
	oxybutynin chloride tab	2.5 MG	Medicaid
	Oxybutynin Chloride Tab 5 MG	5 MG	Medicaid
	Oxybutynin Chloride Tab ER 24HR 15 MG	15 MG	Medicaid
	trospium chloride cap er	60 MG	Medicaid
	trospium chloride tab	20 MG	Medicaid
Detrol	tolterodine tartrate tab	1 MG ; 2 MG	Medicaid
Detrol la	tolterodine tartrate cap er	2 MG ; 4 MG	Medicaid
Ditropan xl	Oxybutynin Chloride Tab ER 24HR 10 MG	10 MG	Medicaid
Ditropan xl	Oxybutynin Chloride Tab ER 24HR 5 MG	5 MG	Medicaid
Gelnique	oxybutynin chloride td gel	10 %	Medicaid
Gemtesa	vibegron tab	75 MG	Medicaid
Myrbetriq	mirabegron granules for oral extended release susp	8 MG/ML	Medicaid
Myrbetriq	mirabegron tab er	25 MG ; 50 MG	Medicaid
Oxytrol ; Oxytrol for women	oxybutynin td patch twice weekly	3.9 MG/24HR	Medicaid
Toviaz	fesoterodine fumarate tab er	4 MG ; 8 MG	Medicaid
Vesicare	solifenacin succinate tab	10 MG ; 5 MG	Medicaid
Vesicare ls	solifenacin succinate susp	5 MG/5ML	Medicaid

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
QL Standalone	**Quantity limit for the Target Agent(s)** will be approved when ONE of the following is met: 1. The requested quantity (dose) does NOT exceed the program quantity limit **OR** 2. The requested quantity (dose) is greater than the program quantity limit AND ONE of the following: A. BOTH of the following: 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication **AND**

Module	Clinical Criteria for Approval
	2. Information has been provided to support therapy with a higher dose for the requested indication **OR** B. BOTH of the following: 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication **AND** 2. Information has been provided to support why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit **OR** C. BOTH of the following: 1. The requested quantity (dose) is greater than the maximum FDA labeled dose for the requested indication **AND** 2. Information has been provided to support therapy with a higher dose for the requested indication **Length of Approval:** up to 12 months