Resident Help Sheet

The Birds Nest Team:

Patient Access Representatives (PAR's)

Manages Clinic schedule/ schedules testing

-**Shanna McCrossen** (x 84171) Cell: 504-710-3956

-**Vanessa Rixner** (x 86859) Cell: 504-236-1457

Urology RN Navigators

-**Renee Lemoine** (x 82865) Cell: 985-226-3329

Schedules surgeries for ALL docs, performs catheter/ enema training, patient teaching. Navigator for Bowel/Bladder clinic and DSD Clinic.

-**Kionne Lear** (x 80193) Cell: 504-458-1649

Schedules surgeries for ALL docs, performs catheter/ enema training, patient teaching. Schedules/ assists with Urodynamics.

-**Judy Zeringue** (x 84275) Cell: 504-494-6925

Schedules surgeries for ALL docs, performs catheter/ enema training, patient teaching. Navigator for Kidney Stone clinic.

Communication Preferences:

-EPIC messaging is preferred over communication via cell. For urgent or time sensitive matters, please send EPIC chat. For all other tasks, ***please send a message via EPIC staff message to the appropriate pool (not individuals).***

-The pool that includes both Shanna and Vanessa is:

P CHNO UROLOGY FRONT DESK POOL

-mainly for messaging regarding clinic follow up

-The pool that includes Renee, Kionne and Judy is:

P CHNO UROLOGY SUPPORT STAFF POOL

-surgery scheduling

-pre-op surgical clearance questions

-help with patient education (CIC, Mitrofanoff, etc.)

-Resident Call schedule should be emailed to Shanna before the end of month. (Shanna.Mccrossen@lcmchealth.org)

Surgery/ Clinic Schedule *(subject to change**, make sure to check as schedule can change significantly week to week**):*

-**Dr. Martin:**

- CHNOLA clinic on 1st Thursday and 3rd Thursday (am only)
- Surgery on 1st Wednesday; 2nd, 3rd, 4th, 5th Tuesdays; Every Friday (except for the 2nd Friday of months March, Jun, Sept, Dec)

-**Dr. Ortenberg:**

-CHNOLA clinic on 4th Tuesday (pm only), 5th Tuesday; 1st, 3rd & 5th Friday, 3rd Thursday (pm only)

-Surgery on 1st Tuesday; 2nd, 3rd, 5th Wednesday; 2nd & 5th Thursday; 2nd Friday of the month (except for months Feb, May, Aug, Nov)

-**Dr. Raines:**

- CHNOLA clinic every Monday; 2nd Thursday
- Surgery on every Tuesday; 1st & 3rd Thursday; 2nd Friday (except for months Jan, Apr, Jul, Oct) & 4th Friday

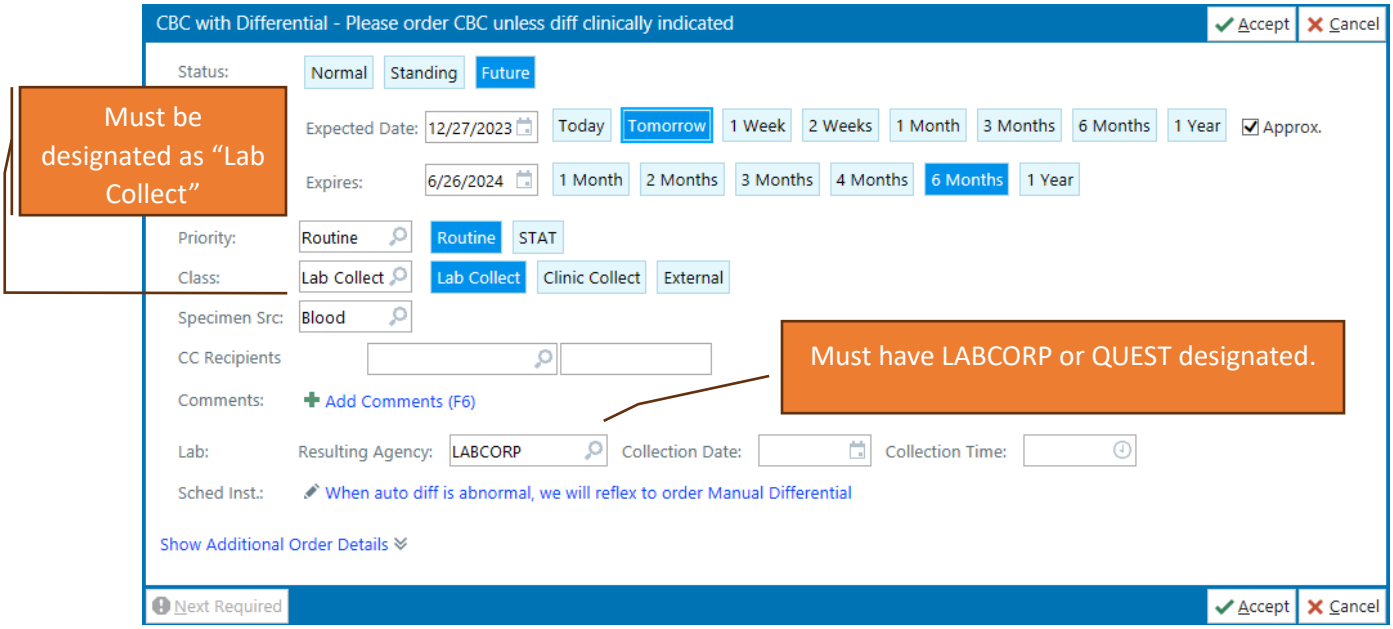
-**Dr. Roth:**

- CHNOLA clinic every Tuesday; 2nd Friday (am only, except months Feb, May, Aug, Nov)
- Surgery every Monday/ Wednesday

Placing Orders:

-support staff are usually pretty good about denoting which changes need to be made to orders when they reach out to the resident

-Some of our patients require pre-op labs to be performed prior to surgery. When this is the case, the nurses will typically reach out to you via EPIC chat or staff message and request that you enter the order. When entering orders for QUEST or LABCORP, please make sure to select "LAB COLLECT". If "EXTERNAL" is selected- the order will NOT route to the designated lab. See below picture for explanation on sending orders to QUEST or LABCORP:



For labs that are being performed at CHNOLA, the Resulting Agency must be designated as LCMC for our lab to be able to see and use the order. For all other lab locations (PCP, external hospital)- the "Resulting Agency" should be left blank with the "Class" designated as "EXTERNAL." When entered this way- the order does not route to a lab but allows the office to print and fax the order to where the patient is going.

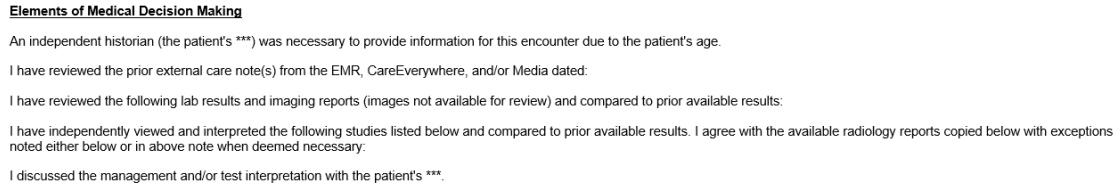
When entering orders for tests that need to be performed here at CHNOLA or any of our satellite clinics, please enter these tests as internal orders. Most of our satellite clinics have the capability to perform ultrasounds, but some do not. More extensive tests such as nuclear med tests or VCUG's, will need to be performed at CHNOLA or an outside hospital. If the plan is for a patient to return to clinic at a satellite location with testing needed, these test orders should be entered EXTERNALLY. **Please note that these External orders do not route anywhere in EPIC- so you must notify Shanna and Vanessa (via message to the pool) to coordinate any outside testing with clinic visit.**

Pediatric Urology Outpatient Clinic Manual

Be on-time to clinic. Unless coming directly from the OR, wear business attire to clinic. If the OR is completed for the day, residents should report to CHNOLA clinic if still on-going to help.

Documentation:

1. Always speak with your attending first to determine preference for documentation and clinic flow. Communication is key to an efficient clinic.
2. If your attending is using a scribe, be sure to decide who will be documenting on patients you see to avoid wasted notes.
3. There are 2 basic documentation templates to use in clinic.
    a. New Patient/Est Patient visit: .churonewvisit
    b. Post-Op visit: .churopostop
4. The resident is always responsible for the following portions of the note:
    a. Dictate/type the detailed HPI, physical exam, data reviewed and plan in letter form at the top of the note as if communicating with the pediatrician. This at minimum should be completed by the end of the clinic day.
    b. For the below section:
        i. In 1st section, at the *** insert which relative/case worker/ caretaker is with patient (e.g. mother, grandfather, etc.)
        ii. In 2nd section, list any relevant past notes reviewed with date of note.
        iii. In 3rd section, copy/paste any relevant labs and imaging reports (if no images to look at)
        iv. In 4th section, copy/paste any imaging reports for images available to review
        v. Delete 5th line unless discussed with an outside physician (rare)



Elements of Medical Decision Making

An independent historian (the patient's ***) was necessary to provide information for this encounter due to the patient's age.

I have reviewed the prior external care note(s) from the EMR, CareEverywhere, and/or Media dated:

I have reviewed the following lab results and imaging reports (images not available for review) and compared to prior available results:

I have independently viewed and interpreted the following studies listed below and compared to prior available results. I agree with the available radiology reports copied below with exceptions noted either below or in above note when deemed necessary:

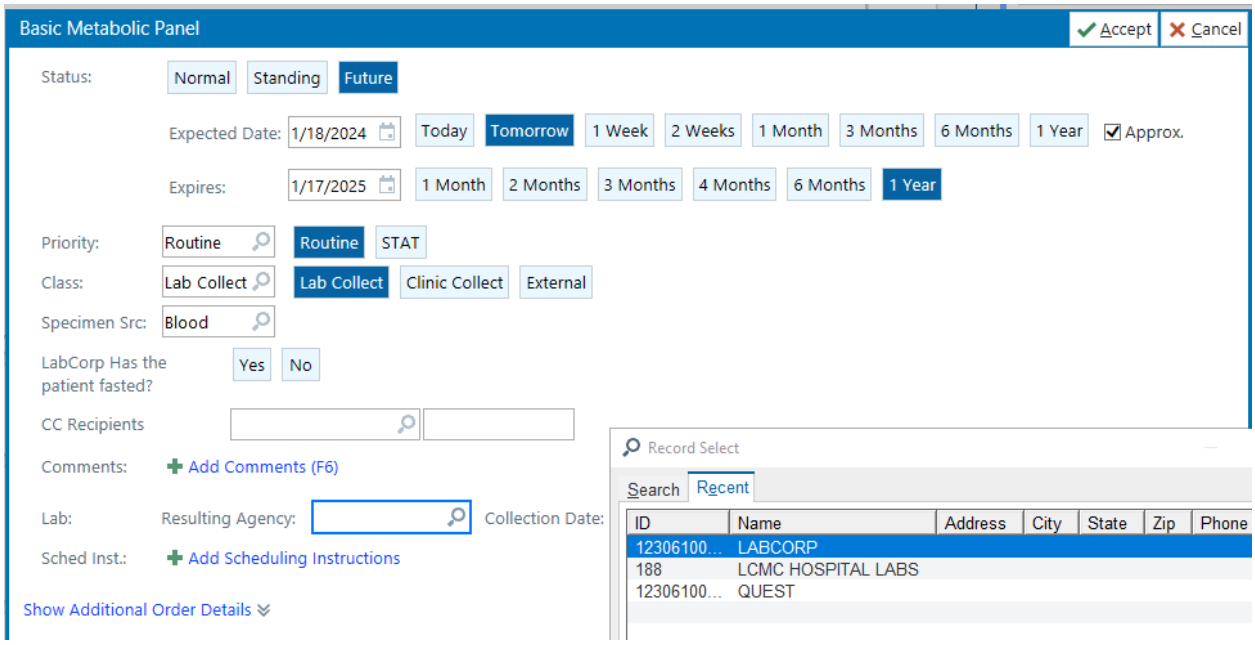
I discussed the management and/or test interpretation with the patient's ***.

c. For a post op note, only the surgery and date need to be filled in with any pertinent post-op issues. The physical exam should be entered and any relevant imaging. The plan should be clear.

5. Check with your attending on their preference for further documentation requests. Below is a list of smartphrases that can be used within the note as well as short procedure notes and AVS instructions that can be used per an attending's preference.
6. For short clinic procedures, a separate note from the clinic note should be created and the phrase below inserted.
7. For newborn circumcisions, there should be a clinic note and a separate procedure note (.churonbcircopnoteam) combined with .procdoc

Special Orders:

1. To request our nurses to schedule a surgery, a message should be sent to CHNO UROLOGY SUPPORT STAFF POOL using the template .churosurgeryrequest. Please order preop labs at the same time.
2. To request FUDS, order FL Urodynamics Study *and* Urodynamic Procedure. Then a message should be sent to Kristen Lindsey and Kionne Lear with the following template .udsform
3. If labs or imaging is requested to be done outside of CHNOLA facilities (external order), a message should be sent to P CHNO UROLOGY FRONT DESK POOL so it can be arranged by Shanna and Vanessa.
    a. If location of lab draw is unknown, it is best to leave the Resulting Agency section blank as shown below:



    b. All imaging orders done at CHNOLA facilities can be listed as "ANCILLARY PERFORMED"

4. For pelvic floor PT, order pediatric physical therapy consult, select external, and put “pelvic floor PT” in the scheduling notes. Send a message to CHNO UROLOGY SUPPORT STAFF POOL to get it scheduled.

SmartPhrases:

For Visit Note:

Atypical genitalia discussion (.joatypicalgenitalia)

Bladder/Bowel discussion (.admbbd)

Clinic Time Attestation (.churotimeattest)

MAG-3 Reporting Template (.admmag3)

MCDK discussion (.jonathxmckd)

Microlithiasis discussion (.jonathxtestmicrolithiasis)

Neurogenic bladder tracking tool (.admsb)

New/Est In-Person Visit (.churonewvisit)

Post-op Visit (.churopostop)

PUV discussion (.jonathxpuvbldr)

RBUS Reporting Template (.admrbus)

Retractile testes discussion phrase (.admretractile)

Surgery Request Form (.churosurgeryrequest) ***send to chno urology support staff pool

Surgery risk phrase with circumcision default (.admcircphrase)

UDS Request Form (.udsform) *** send to Kristen Lindsey and Kionne Lear

Vaginitis discussion (.admvaginitis)

Varicocele discussion (.jonathxvaricocele)

VCUG Reporting Template (.admvcug)

Virtual Visit (.churovv)

For Clinic Procedure Note:

FUDS report (.admfudsreport)

Newborn circumcision note (.churonbcircopnoteam) ***Be sure to use .procdoc as well

Office meatotomy (.admmeatotomy)

Office skin bridge excision (.admskinbridge)

Uroflow/EMG report (.admuroemg)

For AVS:

24 hour Urine collection (.24hrurine)

Alarm with imipramine treatment (.joalarmimipramine)

Bedwetting alarm instructions (.joalarminstruct)

Bladder and Bowel Habits (.instrvoidinginstructions)

CIC instructions (.instrcic)

DDAVP Instructions (.DDAVP)

Detailed bowel cleanouts by age (.sherrycleanoutage…)

General Nephrolithiasis Information (.stoneinfo)

Gentamicin bladder irrigation protocol (.admgentflush)

Hydronephrosis information (.instrhydronephrosis)

Hypospadias information (.instrhypospadiascaregiverinfo)

Imipramine instructions (.imipramine)

Newborn circumcision post-op instructions (.martinnbcirc)

Nocturnal enuresis information (.instrnocturnalenuresis)

Phimosis/Steroid cream instructions (.instrbetamethasone)

Prenatal hydronephrosis information (.joinfoprenatalhydro)

Surgery Scheduling Call (.instrsurgscheduling)

Testicular Self Exam (.instrtesticularselfexams)

UDT information (.instrudt)

Uncircumcised phallus care (.careofuncircpenis)

UPJO/Pyeloplasty information (.instrupjo)

VCUG information (.instrvcug)

VUR Diagram (.vurdiagrams)

VUR grades chart (.vurgrades)

VUR Information (.instrvur)

VUR Resolution Rate Chart (.vurresolutionchart)

Hospital and OR Operations for Urology Residents

- Inpatient Management
    - Consults
        - No consult is a 'bad' consult. We trust you to gauge the clinical urgency and determine when within the day a consult is seen, but the general expectation is that all consults are seen the day they are received.
        - If a consult is requested after you have left for the day and the consulting team does not need you to see the patient that evening, you can see it in the morning (i.e. consult for circumcision). Most evening consults tend to be for urgent matters and may require a return to the hospital.
        - The attending on call is responsible for staffing consults that day. If it is a well-known patient of a certain attending, you can call that attending first to see if they can help with the current issue or does the attending on call need to staff it.
        - Many consults can be signed off on prior to discharge though confirm with the attending before signing off.
        - ED consults should typically be seen minimum within one hour of receiving the consult unless emergent (torsion, paraphimosis should be within 30min).
    - Primary Patients
        - We won't typically have a large census and we expect that all inpatients are seen twice per day.
        - The attending responsible for the admission should be notified daily of the progress.
        - We are not pediatricians so for medically complex patients, it is often best to consult the pediatrics team for help with management.
            - A general rule of thumb is that if the attendings aren't sure how to do something (i.e. sliding scale insulin, significant fluid and electrolyte issues, prolonged respiratory needs) it is best to get a consultation vs. doing this yourself.
        - Do not copy the prior day's notes. This leads to documentation errors. The entire history does not need to be repeated in each note and the primary focus

is significant events of last 24 hours, noted vital sign and exam findings, lab and imaging results, and assessment in plan.

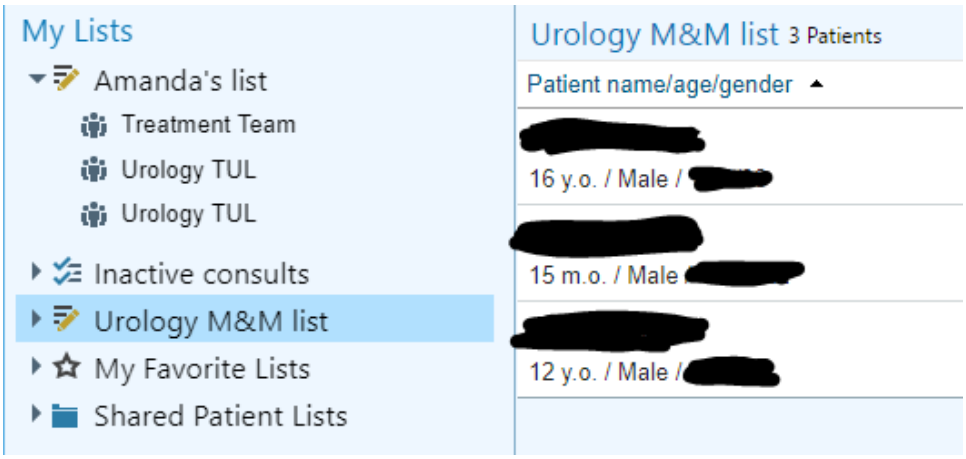
- OR management
    - Pre-op Planning
        - The cases for the following week with be reviewed at Tuesday conference.
            - The residents can alternate roles for who is presenting on a given week.
            - This is a learning opportunity for complex patients and a quality control measure for all cases.
            - This is a good time to remind the team of absences the following week. If this creates an issue with case coverage, options for coverage need to be discussed.
        - A case that has relevant imaging, the imaging should be available and reviewed. Most imaging should be available with the noted exception that imaging done at Woman's Hospital Baton Rouge may not be requested as it can be accessed.
            - https://rad.womans.org/
            - ID: MD-JO, Password: izsc90
        - The RN team will take care of obtaining clearances and labs. If you see something in the history of question, please note. The most common clearance is cardiology though Heme/Onc, Endocrine, and Neurology are others. Clearance by PCP isn't typically sought though may be requested if there has been a recent viral illness.
    - OR Attendance
        - OR coverage is the primary daily responsibility.
            - Typically, there is one resident per case though if there is a case of significant interest both residents can attend the case if the other attendings agree that they don't need help in OR or clinic.
        - You should be prepared with clinical history, review of imaging, and surgical plans. All of this should be discussed at case conference the week prior but pay attention to add-ons or other cases that you may not have prepared for.
    - Short Stay Unit Process
        - Pre-Op
            - Don't be the reason for a case delay! Get the H/P and consent done as soon as the patient is roomed in Short Stay.
            - Different attendings have different preferences for seeing patients before they go back to the OR. You don't have to monitor this though do notify the attending if the patient has significant questions, new findings, or a direct request for attending visit prior to rolling back.
            - Rashes: common in the diapered kids. A rash not in the area of the planned incision is of little concern. A mild rash in the area of the planned incision may not be significant if it's a simple operation and the rash does not appear secondarily infected. To be safe, notify the attending of rashes and let them guide you on how it could affect case.

- Post-op
    - The attending will visit with family after the case and you will work on discharge paperwork.
        - Almost all patients will go home on ibuprofen (10 mg/kg q6) and acetaminophen (15 mg/kg q6). See medication section for guidance on dosing.
        - Ask about any additional meds that are needed: antibiotics, ditropan, etc
        - Before prescribing narcotics, check with the attending
        - Ask the attending about follow-up plans as some may require specific timing of visits for catheter removals, etc. Some patients may only need follow-up visits as needed (circumcisions).
    - Post-op Instructions:
        - We have standard post-op instructions for circumcisions:
            - Circumcision: CHUROCIRCPOSTOP
            - There also may be different post-op circumcision instructions based on provider
        - For all other cases, look for the attending-specific instructions.
        - Instructions should go in the 'instructions' section in the discharge tab
    - Op Notes
        - Ok to use templates for circumcision though note each attending does them differently.
        - For all other cases it is best to dictate so that you can learn the surgical steps and make sure that variances in the technique or findings are noted.
        - If there are questions regarding procedures being billed/listed as done in that procedure i.e during hypospadias repairs please discuss with attending what you should list

M&M Conference

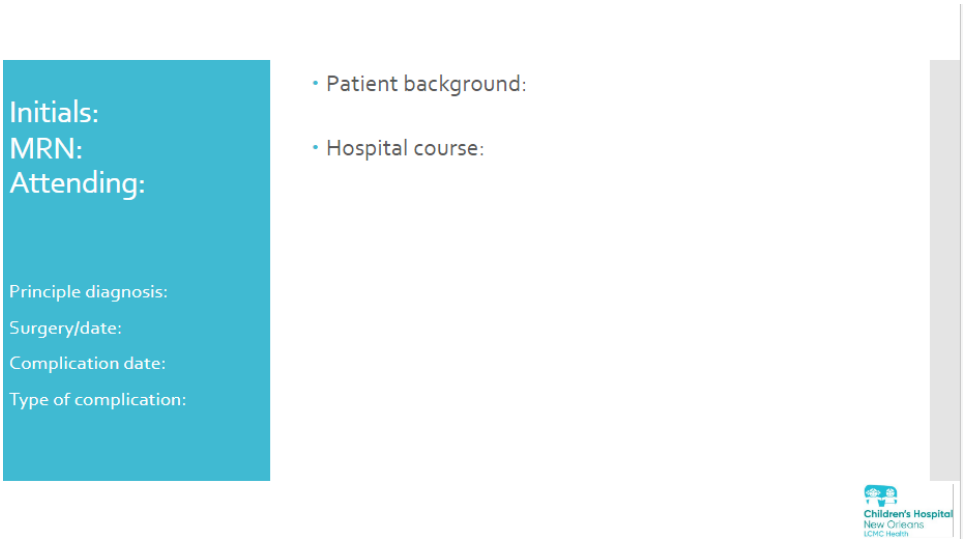
- We have a monthly M&M conference on the 4th Tuesday of the month. Residents will present the cases and we will aim to have the resident who performed the case present it, but that may not always work out. During conference the week before M&M we will briefly go over the list and ask the group if there are any additional cases to add. After that cases will be assigned to each resident. Dr. Raines will send out a powerpoint template for you to fill out for your patients and you will send slides back to her to compile.

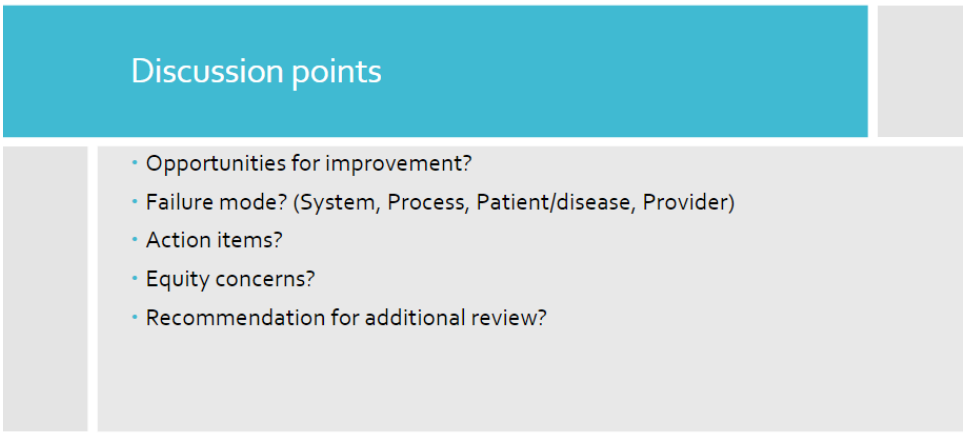
- There is a shared M&M list for us to track patients to be presented. This list will show up alongside your other patient lists. (see below)



- When you become aware of a patient complication, please add them to the list. This can be done by right clicking on the list and then selecting add patient. While most patient's we will discuss will be what you classically think of complications, we also want to discuss other cases in which there is room for improvement such as near misses. If you think a patient could be appropriate for M&M add to the list and we can assess need to present.

- Below are samples of the powerpoint template slides. Please fill in all the information on both slides for each patient. If you are unsure what to put particularly for the 2nd slide please discuss with attending for the case or Dr. Raines. When making the presentation for the patient you may add extra slides to include full medical course and any pertinent images. You may also include a brief literature review when appropriate.





Medication	Standard Dose	Adolescent dose	Range/Max dose	Restrictions
Pain medications				
Tylenol	15 mg/kg q6 hrs	650 mg q6hrs	10-15 mg/kg Max: 75 mg/kg/day or 4000 mg/day	
Ibuprofen	10 mg/kg q6hrs	400 mg q4hrs	Max: 40 mg/kg/day or 2400 mg/day	Do not use in infants <6 months; Solitary kidney; CKD
Toradol (IV)	0.5 mg/kg q6hrs	15 mg q6hrs	Range: 0.3-0.5 mg/kg Max: 30 mg/dose	Do not exceed 5 days duration
Oxycodone	0.1 mg/kg q4hrs	5 mg q4hrs	Range: 0.1-0.2 mg/kg Max: 10 mg/dose	Avoid if <6 months old
Morphine	<6 mo: 0.025 mg/kg q4hrs >6 mo: 0.05 mg/kg q4hrs	2 mg q4 hrs	Range: <6 mo 0.025-0.05 mg/kg >6 mo 0.05-0.1 mg/kg Adolescent 2-5 mg	Infants <3 mo need to be on monitor
Bladder medications				
Oxybutynin	0.1 mg/kg q8hr	5 mg TID or ER 5 to 15 mg per day	Max: 0.6 mg/kg/day	Transdermal patch: >4 yo 3.9 mg patch q3-4 days
Tolterodine (detrol)	0.12 mg/kg/day	1-2 mg BID		
Mirabegron	Granules in children >3 yo: 11-22 kg: 24 mg daily 22-35 kg: 32 mg daily >35 kg: 48 mg daily	Tablet: 25 mg daily	Max: 11-22 kg: 48 mg qd 22-35 kg: 64 mg qd	

<table>
<tr><td></td><td></td><td></td><td>>35 kg: granules-80 mg qd; tablet 50 mg qd</td><td></td></tr>
<tr><td>Tamsulosin</td><td>0.2 mg QHS</td><td>0.4 mg QHS</td><td>Start with 0.2 mg and can titrate to 0.4 mg Max: 0.8 mg/day</td><td></td></tr>
<tr><td>DDAVP</td><td>0.2 mg/day</td><td>0.2 mg/day</td><td>Titrate to a max of 0.6 mg/day</td><td>Age 6+</td></tr>
<tr><td>Imipramine</td><td>10 mg daily</td><td>10 mg daily</td><td>Titrate up by 10 mg increments weekly to max dose of 50 mg daily</td><td>Dosing for nocturnal enuresis</td></tr>
<tr><td colspan="5">Bowel medications</td></tr>
<tr><td>Miralax</td><td>0.8 mg/kg/day</td><td>17 g/day</td><td>0.2-1.5 mg/kg/day</td><td></td></tr>
<tr><td colspan="5">Antibiotics: UTI treatment dosing</td></tr>
<tr><td>Cephalexin (Keflex)
250 mg/5ml</td><td>1 mo-14 yrs, <20 kg: 25 mg/kg q8hrs
2 mo-14 yrs, ≥ 20 kg: 500 mg q8hrs</td><td>Cystitis: 500 mg PO q12hrs
Pyelonephritis: 500 mg PO q8 hrs</td><td>Range: 25-50 mg/kg/day every 6 hrs (mild/mod)
50-100 mg/kg/day q6-8 hrs (severe)
Max: 1000 mg</td><td></td></tr>
<tr><td>Nitrofurantoin
25 mg/5ml</td><td>Use nitrofurantoin macrocrystals unless otherwise noted<table><tr><td>Wt (kg</td><td>Dose</td><td>Freq</td></tr><tr><td><12kg</td><td>1.5 mg/kg liquid</td><td>4x/ day</td></tr><tr><td>12-21.9 kg</td><td>25 mg cap</td><td>4x/ day</td></tr><tr><td>22-41.9 kg</td><td>50 mg cap</td><td>4x/ day</td></tr><tr><td>≥ 42 kg AND <12 yo</td><td>100 mg (2 caps)</td><td>4x/ day</td></tr></table></td><td>Use nitrofurantoin macrocrystals monohydrate (MacroBID)
≥42 kg AND ≥12 yrs: 100 mg 2x/day</td><td>Range: 5-7 mg/kg/day every 6 hrs, nitrofurantoin macrocrystals
Max: 100 mg/dose</td><td>Do not use in infants <2 months of age. Do not use for pyelonephritis.</td></tr>
<tr><td>Trimethoprim-sulfamethoxazole (Bactrim) 40-200 mg/5 ml</td><td>5 mg/kg BID (TMP)</td><td>160 mg (TMP) BID</td><td>Range: 6-12 mg/kg/day
Max: 160 mg TMP/dose</td><td>Do not use in infants < 2 months of age</td></tr>
<tr><td>Amoxicillin 400 mg/5ml</td><td><3 months: 10 mg/kg BID
>3 months: 13 mg/kg q8</td><td>250 mg q8hrs</td><td>Range: <3 mo 20-30 mg/kg/day BID</td><td></td></tr>
</table>

			>3 mo 25-50 mg/kg/day q8hrs	
Cefprozil 250 mg/5ml	15 mg/kg BID	500 mg BID	Range: 15-30 mg/kg/day every 12 hrs Max: 500 mg BID	Suspension alternative to cefuroxime
Amoxicillin-clavulanate (Augmentin) 400-57 mg/5 ml	15 mg/kg BID	875/125 mg BID	Range: 2-24 mo 20-40 mg/kg/day BID Max: 875 mg BID	
Cefdinir (omnicef) 250 mg/5 ml	7 mg/kg BID	300 mg BID	Max: 300 mg BID	<6 months has not been studied *preferred 3rd gen cephalosporin for insurance
Cefpodoxime 100 mg/5 ml	5 mg/kg BID	Cystitis: 100 mg BID Pyelonephritis: 200 mg BID	Range: 100-400 mg BID Max: liquid 100 mg BID Adolescent: 800 mg/day	<2 months has not been studied
Levofloxacin (Levaquin) 25 mg/ml	10 mg/kg BID	Cystitis: 250 mg daily Pyelonephritis: 750 mg daily	Max peds dose: 750 mg daily	
Cefixime (Suprax) 100 mg/5 ml	4 mg/kg BID	400 mg daily	Max peds: 200 mg BID	<6 months has not been studied
Fosfomycin (Monurol) 3 g/packet	< 10 kg 1 g q72 hrs 10-20 kg 2 g q72 hrs >20 kg 3 g q72 hrs	3 gm q72 hrs	Max: 3 g	Do not use for pyelonephritis. Mix packet in 3 oz of water. For 1 g dose give 1 oz of the mix, for 2 g dose give 2 oz of mix, for 3g give 3 oz of mix.
Antibiotic: Prophylaxis dosing				
Amoxicillin 400 mg/5 ml	10 mg/kg once daily			Not recommended for patients >2 mo given increasing E coli resistance.
Bactrim 40 mg-200 mg/5 ml	2 mg/kg (TMP) once daily		Max: 80 mg (TMP) once daily	Do not use in infants <2 months of age.

<table>
<tr><td>Nitrofurantoin 25 mg/ml</td><td>1 mg/kg once daily<table><tr><td>Wt (Kg)</td><td>Dose</td></tr><tr><td><12 mg</td><td>1 mg/kg liquid</td></tr><tr><td>12-24.9 kg</td><td>25 mg cap</td></tr><tr><td>25-49.9 kg</td><td>50 mg cap</td></tr><tr><td>≥ 50 kg</td><td>100 mg cap</td></tr></table></td><td>100 mg macrocrystal capsule</td><td>Range: 1-2 mg/kg/day</td><td>Do not use in infants <2 months of age. Contraindicated in patients with a previous history of cholestatic jaundice or hepatic dysfunction associated with nitrofurantoin</td></tr>
<tr><td>Cephalexin (Keflex) 250 mg/5 ml</td><td>10 mg/kg once daily</td><td></td><td>Max: 250 mg once daily</td><td></td></tr>
<tr><td>Fosfomycin (Monurol) 3 g/packet</td><td>< 10 kg 1 g qweek
10-20 kg 2 g qweek
>20 kg 3 g qweek</td><td>3 g qweek</td><td>Max: 3 g</td><td>Mix packet in 3 oz of water. For 1 g dose give 1 oz of the mix, for 2 g dose give 2 oz of mix, for 3g give 3 oz of mix.</td></tr>
<tr><td colspan="5">Bladder irrigations</td></tr>
<tr><td>Gentamicin</td><td>480 mg Gent diluted in 1 L of normal saline</td><td>Instill 30-60 ml twice daily</td><td></td><td></td></tr>
<tr><td>Tobramycin</td><td>480 mg Tobra in 1 liter of normal saline</td><td>Instill 30-60 ml twice daily</td><td></td><td></td></tr>
<tr><td>Fosfomycin</td><td>1 packet (3 gm) diluted in 125 ml of sterile water</td><td></td><td></td><td></td></tr>
</table>

***Age based dosing should be based on corrected gestational age for premature infants.**

UTI Treatment Duration recommendations:

Infection	Treatment duration
Cystitis	**5 days (complicated 7 to 10 days)**
Pyelonephritis	**10 days (complicated 14 days)**

UROLOGY INCONTINENCE (61)	Fesoterodine Fumarate ER Tablet (Generic; Toviaz®)	Darifenacin ER Tablet (Generic)
Bladder Relaxant Preparations	Mirabegron ER Tablet (Myrbetriq®)	Flavoxate Tablet (Generic)
*Request Form	Oxybutynin Syrup (Generic)	Mirabegron ER Granules for Oral Suspension (Myrbetriq®)
*Criteria	Oxybutynin Tablet (Generic)	Oxybutynin ER Tablet (Ditropan XL®)
*POS Edits	Oxybutynin ER Tablet (Generic)	Oxybutynin Transdermal Gel (Gelnique®)
	Solifenacin Tablet (Generic)	Oxybutynin Transdermal Patch Rx (Oxytrol®)
		Solifenacin Tablet, Suspension (VESIcare®; VESIcare® LS)
		Tolterodine Tablet (Generic; Detrol®)
		Tolterodine ER Capsule (AG; Generic; Detrol LA®)
		Trospium Tablet (Generic)
		Trospium ER Capsule (Generic)
		Vibegron Tablet (Gemtesa®)