CLINICAL REFERENCE · OVERACTIVE BLADDER

OAB medication list

Every agent used to treat overactive bladder in the US, with class, dosing range, formulation and the safety flag that decides who gets it. Check each figure against current prescribing information before you prescribe.

1 Drug classes at a glance

Drug (brand)	Class	Typical adult dose	Formulations	Key note
Oxybutynin Ditropan, Ditropan XL, Oxytrol, Gelnique	Anticholinergic	10–20 mg/day (IR, divided) 5–30 mg/day (ER)	IR tablet, ER tablet, patch, gel	Highest CNS penetration of the class. Beers Criteria say avoid the immediate-release form in adults 65 and over.
Tolterodine Detrol, Detrol LA	Anticholinergic	2–4 mg/day	IR tablet, ER capsule	M2/M3 antagonist. Fewer central effects than oxybutynin.
Solifenacin VESIcare	Anticholinergic	5–10 mg once daily	Tablet	M3-selective. Studied in combination with mirabegron.
Darifenacin Enablex	Anticholinergic	7.5–15 mg once daily	ER tablet	M3-selective. Cap at 7.5 mg with a strong CYP3A4 inhibitor.
Fesoterodine Toviaz	Anticholinergic	4–8 mg once daily	ER tablet	Prodrug converted to the active metabolite of tolterodine. Titrate after four weeks.
Trospium Sanctura, Sanctura XR	Anticholinergic	20 mg twice daily (IR) 60 mg once daily (ER)	IR tablet, ER capsule	Hydrophilic, so it barely crosses the blood-brain barrier. Preferred anticholinergic in older adults.
Flavoxate Urispas	Urinary antispasmodic	100–200 mg three or four times daily	Tablet	Approved for urinary symptoms of lower tract inflammation, not for OAB itself. Also on the Beers list.
Mirabegron Myrbetriq	Beta-3 agonist	25–50 mg once daily	ER tablet, granules for suspension	Raises blood pressure and inhibits CYP2D6. Check pressure at baseline and at review.
Vibegron Gemtesa	Beta-3 agonist	75 mg once daily	Tablet	Fixed dose, no titration. Minimal CYP interactions and no pressure signal in trials.

Anticholinergics block muscarinic receptors on the detrusor. Beta-3 agonists relax the detrusor during filling instead, which avoids dry mouth and constipation.

2 Starting dose, ceiling and organ adjustments

Drug	Starting dose	Maximum dose	Renal and hepatic adjustment
Oxybutynin IR	5 mg two or three times daily	20 mg/day	Start at 2.5 mg two or three times daily in frail older adults. Use caution in hepatic or renal impairment.
Tolterodine ER	4 mg once daily	4 mg/day	2 mg/day with reduced hepatic or renal function, or with a strong CYP3A4 inhibitor.
Solifenacin	5 mg once daily	10 mg/day	Maximum 5 mg/day if CrCl is under 30 mL/min or hepatic impairment is moderate.
Darifenacin	7.5 mg once daily	15 mg/day	Maximum 7.5 mg/day in moderate hepatic impairment. Avoid in severe hepatic impairment.
Fesoterodine	4 mg once daily	8 mg/day	Maximum 4 mg/day if CrCl is under 30 mL/min or with a strong CYP3A4 inhibitor.
Trospium IR	20 mg twice daily	20 mg twice daily	20 mg once daily at bedtime if CrCl is under 30 mL/min. The ER form is not recommended there.
Flavoxate	100 mg three or four times daily	800 mg/day	No numeric adjustment published. Contraindicated in obstructive uropathy and GI obstruction.
Mirabegron	25 mg once daily	50 mg/day	Maximum 25 mg/day if eGFR is 15 to 29 or hepatic impairment is moderate. Avoid below that.
Vibegron	75 mg once daily	75 mg/day	No adjustment in mild to moderate impairment. Not recommended in severe renal or hepatic impairment.

3 Which class fits which patient

What you find in the history	Start here	Why
Narrow-angle glaucoma	Beta-3 agonist	Anticholinergics are contraindicated in untreated narrow-angle glaucoma.
Dementia, delirium or cognitive concern	Beta-3 agonist	Central muscarinic blockade adds confusion risk. Beta-3 agonists have no such effect.
Severe constipation or slow gut transit	Beta-3 agonist	Anticholinergics slow motility further.
Age 75 and over, otherwise well	Beta-3 agonist or trospium	Trospium is hydrophilic, so central exposure stays low.
Uncontrolled hypertension	Anticholinergic	Mirabegron is not recommended when systolic pressure reaches 180 mmHg.
On a tricyclic or a class 1C antiarrhythmic	Vibegron or an anticholinergic	Mirabegron inhibits CYP2D6 and raises those drug levels.
Urinary retention or high post-void residual	Neither, investigate first	Both classes can worsen incomplete emptying.
None of the above	Either class	Cost, formulation and coverage usually decide it.

4 Before you prescribe

- [ ] Behavioral therapy tried and documented
- [ ] Bladder diary or symptom score recorded at baseline
- [ ] Post-void residual checked where retention is possible
- [ ] Narrow-angle glaucoma ruled out
- [ ] Current anticholinergic burden totalled
- [ ] Blood pressure recorded before a beta-3 agonist
- [ ] Renal and hepatic function reviewed against the ceiling
- [ ] Formulary and step-therapy rules checked
- [ ] Onset explained: four to eight weeks to judge
- [ ] Review appointment booked at four to eight weeks

5 Review visit record

Date	Agent and dose	Blood pressure	Response, side effects, action

6 Notes