Pharmacy Drug Policy & Procedure

Policy Name:	Phenoxybenzamine	Policy #:	2420P

Purpose of the Policy

The purpose of this policy is to establish the criteria for coverage of phenoxybenzamine.

Statement of the Policy

Health Alliance Medical Plans will approve the use of phenoxybenzamine when the following criteria have been met.

Criteria

1. Coverage Criteria

1.1 Documented diagnosis of pheochromocytoma

1.2 Documented failure, intolerance, or contraindication to prazosin, terazosin, and doxazosin

2. Exclusions

2.1 Phenoxybenzamine is not covered for the treatment of peripheral vascular diseases

- It has been used as adjunctive therapy in the treatment of peripheral vasospastic disorders associated with increased *a*-adrenergic activity† (e.g., Raynaud's syndrome, acrocyanosis, or frostbite sequelae) but it has not been proven effective for these conditions

3. Managed Dose Limit

3.1 Phenoxybenzamine will have a managed dose limit of #14 capsules per 30 days

3.2 An increase in the MDL to #30 capsules per 30 days will be approved with documentation of recent heart attack, catecholamine cardiomyopathy, treatment resistant high blood pressure or catecholamine- induced vasculitis.

4. Approval Period

4.1 6 months

CPT Codes

HCPCS Codes

References

1. Dibenzyline (phenoxybenzamine) [prescribing information]. St. Michael, Barbados: Concordia Pharmaceuticals Inc; July 2023.
2. Kinney MA, Narr BJ, and Warner MA, "Perioperative Management of Pheochromocytoma," J Cardiothorac Vasc Anesth, 2002, 16(3):359-69.
3. Lenders JW, Duh QY, Eisenhofer G, et al. Pheochromocytoma and paraganglioma: an endocrine society clinical practice guideline. J Clin Endocrinol Metab 2014; 99:1915.
4. Tauzin-Fin P, Sesay M, Gosse P, Ballanger P. Effects of perioperative alpha1 block on haemodynamic control during laparoscopic surgery for phaeochromocytoma. Br J Anaesth 2004; 92:512.

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DISCLAIMER

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