



PHARMACY COVERAGE GUIDELINES
SECTION: DRUGS

ORIGINAL EFFECTIVE DATE: 5/21/2020
LAST REVIEW DATE:
LAST CRITERIA REVISION DATE:
ARCHIVE DATE:

DIBENZYLINE® (phenoxybenzamine) oral capsule PHENOXYBENZAMINE oral capsule

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. All other trademarks and service marks contained in this guideline are the property of their respective owners, which are not affiliated with BCBSAZ.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the [request form](#) in its entirety with the chart notes as documentation. **All requested data must be provided.** Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**



PHARMACY COVERAGE GUIDELINES
SECTION: DRUGS

ORIGINAL EFFECTIVE DATE: 5/21/2020
LAST REVIEW DATE:
LAST CRITERIA REVISION DATE:
ARCHIVE DATE:

DIBENZYLINE® (phenoxybenzamine) oral capsule PHENOXYBENZAMINE oral capsule

Criteria:

- **Criteria for initial therapy:** Dibenzyline and phenoxybenzamine is considered *medically necessary* and will be approved when **ALL** of the following criteria are met:

1. Individual is 18 years of age or older
2. A confirmed diagnosis of pheochromocytoma with episodes of hypertension and sweating
3. For Dibenzyline: Individual has failure, contraindication or intolerance to generic oral phenoxybenzamine

Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Dibenzyline and phenoxybenzamine is considered *medically necessary* and will be approved when **ALL** of the following criteria are met:

1. Individual's condition has responded while on therapy
 - Response is defined as:
 - Blood pressure is controlled
 - No significant sweating
2. Individual has been adherent with the medication
3. Individual has not developed any significant level 4 adverse drug effects that may exclude continued use
 - Significant adverse effect:
 - No significant episodes of postural hypotension
 - No episodes of significant tachycardia
 - No significant episodes of dizziness or fainting
4. There are no significant interacting drugs

Renewal duration: 12 months

Description:

Dibenzyline (phenoxybenzamine hydrochloride) is a long-acting, adrenergic, *alpha*-receptor-blocking agent, is indicated in the treatment of pheochromocytoma, to control episodes of hypertension and sweating.

It increases blood flow to the skin, mucosa and abdominal viscera, and lowers both supine and erect blood pressures.



PHARMACY COVERAGE GUIDELINES
SECTION: DRUGS

ORIGINAL EFFECTIVE DATE: 5/21/2020
LAST REVIEW DATE:
LAST CRITERIA REVISION DATE:
ARCHIVE DATE:

DIBENZYLINE® (phenoxybenzamine) oral capsule
PHENOXYBENZAMINE oral capsule

Resources:

Dibenzylamine (phenoxybenzamine) product information accessed 05-14-20 at DailyMed
