BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINES	
SECTION: DRUGS	
ORIGINAL EFFECTIVE DATE:	**5/21/2020**
LAST REVIEW DATE:	**5/19/2022**
LAST CRITERIA REVISION DATE:	**5/19/2022**
ARCHIVE DATE:	

DIBENZYLINE® (phenoxybenzamine)
Phyenoxybenzamine

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.

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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.**

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Criteria:

- **Criteria for initial therapy:** Dibenzyline (phenoxybenzamine) and phenoxybenzamine are 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 **ONE** of the following:
     a. Pheochromocytoma with episodes of headache, sweating, and tachycardia with or without paroxysmal hypertension

     b. Other request for a specific oncologic direct treatment use that is found and listed in the National Comprehensive Cancer Network (NCCN) Guidelines with Categories of Evidence and Consensus of 1 and 2A

  3. **For brand Dibenzyline only**: Individual has failure, contraindication per FDA label, or intolerance to generic oral phenoxybenzamine

  4. Documented failure, contraindication per FDA label, intolerance to **ALL** the following:
     a. Doxazosin
     b. Prazosin
     c. Terazosin

  Initial approval duration: 6 months

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

  1. Individual's condition has responded while on therapy
     a. Response is defined as:
        i. Blood pressure is controlled
        ii. No significant sweating

  2. Individual has been adherent with the medication

  3. Individual has not developed any significant adverse drug effects that may exclude continued use
     a. Significant adverse effect:
        i. No significant episodes of postural hypotension
        ii. No episodes of significant tachycardia
        iii. No significant episodes of dizziness or fainting

  4. There are no significant interacting drugs

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Renewal duration: 12 months

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. **Off-Label Use of Non-Cancer Medications**
2. **Off-Label Use of Cancer Medications**

Description:

Phenoxybenzamine (Dibenzyline and generics) 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.

Resources:

Dibenzyline (phenoxybenzamine) product information, revised by Concordia Pharmaceuticals Inc. 04-2020. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed April 29, 2022.

Phenoxybenzamine product information, revised by Par Pharmaceuticals, Inc. 05-2017. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed April 29, 2022.

Young WF, Kebebew E. Treatment of pheochromocytoma in adults. In: UpToDate, Nieman LK, Carty SE, Martin KA, Chen W (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Topic last updated February 12, 2021. Accessed April 29, 2022.

Young WF. Clinical presentation and diagnosis of pheochromocytoma. In: UpToDate, Nieman LK, Martin KA (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Topic last updated April 13, 2021. Accessed April 29, 2022.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Neuroendocrine and Adrenal Tumors Version 2.2020 – Updated July 24, 2020. Available at https://www.nccn.org. Accessed April 04, 2021.

Off Label Use of Cancer Medications: A.R.S. §§ 20-826(R) & (S). Subscription contracts; definitions.

Off Label Use of Cancer Medications: A.R.S. §§ 20-1057(V) & (W). Evidence of coverage by health care service organizations; renewability; definitions.