Pharmacy Drug Policy Checklist

POLICY NAME	Phenoxybenzamine	POLICY #	2420P

Criteria

Coverage Criteria

- ☐ **1.1** Documented diagnosis of pheochromocytoma
- ☐ **1.2** Documented failure, intolerance, or contraindication to prazosin, terazosin, and doxazosin

Exclusion Criteria – Any of the following prevents coverage

- ☐ **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