

<b>POLICY NAME</b>	Phenoxybenzamine	<b>POLICY #</b>	2420P
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## Criteria

### Coverage Criteria

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

### Exclusion Criteria – Any of the following prevents coverage

- ☐ 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  $\alpha$ -adrenergic activity† (e.g., Raynaud's syndrome, acrocyanosis, or frostbite sequelae) but it has not been proven effective for these conditions