PA Request Criteria

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CAREFIRST - MD EXCHANGE 5T
Dibenzyline (HMF)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Dibenzyline (HMF).

Patient Name: _____ **Date:** 11/29/2023
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (select from list of drugs shown)
Phenoxybenzamine

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1.	Is the requested drug being prescribed for the treatment of pheochromocytoma or paraganglioma to control episodes of hypertension and sweating?	**Y** ☐	**N** ☐
2.	Has the patient experienced an inadequate treatment response to an alpha 1 selective adrenergic receptor blocker (e.g., doxazosin, prazosin, terazosin)?	**Y** ☐	**N** ☐
3.	Has the patient experienced an intolerance to an alpha 1 selective adrenergic receptor blocker (e.g., doxazosin, prazosin, terazosin)?	**Y** ☐	**N** ☐
4.	Does the patient have a contraindication that would prohibit a trial of an alpha 1 selective adrenergic receptor blocker (e.g., doxazosin, prazosin, terazosin)?	**Y** ☐	**N** ☐
5.	Does the patient require MORE than the plan allowance of 12 capsules per day?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

Effective July 1, 2015, Maryland law will require providers to submit pharmaceutical preauthorization requests electronically. To use ePA, either contact your electronic health record vendor or visit www.covermymeds.com/epa/caremark