



Please complete ALL information below and fax your request to 1-888-671-5285

Dibenzylamine[®] (phenoxybenzamine) Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

| Member Information (required) | | | Provider Information (required) | | |
|-------------------------------|--------|------|---------------------------------|------------|------|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

| Medication Information (required) | | |
|---|---------------------|--------------|
| Medication Name: | Strength: | Dosage Form: |
| <input type="checkbox"/> Check if generic substitution is acceptable | Directions for Use: | |
| <input type="checkbox"/> Check if request is for continuation of therapy | | |

| Clinical Information (required) | |
|---|--|
| Select the diagnosis below: | |
| <input type="checkbox"/> Pheochromocytoma | |
| <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____ | |

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

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