



## Commercial/Healthcare Exchange PA Criteria Effective: January 1, 2020

**Prior Authorization:** metyrosine

**Products Affected:** Demser (metyrosine) oral capsules, metyrosine oral capsules

**Medication Description:** Demser (metyrosine) is a tyrosine hydroxylase inhibitor indicated in the treatment of pheochromocytoma.

**Covered Uses:**

Treatment of patients with pheochromocytoma for:

1. Preoperative preparation of patients for surgery
2. Management of patients when surgery is contraindicated
3. Chronic treatment of patients with malignant pheochromocytoma

**Exclusion Criteria:**

1. Treatment of essential hypertension

**Required Medical Information:**

1. Diagnosis

**Age Restrictions:** 12 years of age and older

**Prescriber Restrictions:** Prescribed by, or in consultation with, an endocrinologist or a physician who specializes in the management of pheochromocytoma.

**Coverage Duration:** 12 months

**Other Criteria:**

Approve if the patient meets the following criteria:

1. The patient has a diagnosis of pheochromocytoma; **AND**
2. The patient has a surgical resection planned, has a contraindication to surgery, or has malignant pheochromocytoma.

**References:**

1. Demser™ capsules [prescribing information]. Bridgewater, NJ: Valeant Pharmaceuticals; December 2017.
2. Micromedex® Healthcare Series: Thomson Micromedex, Greenwood Village, Co. 2019.



Rev #	Type of Change	Summary of Change	Sections Affected	Date
1	New Policy	New Policy	All	10/18/2019
2	Update	Added generic metyrosine to policy	Products Affected	8/11/2020