

Prescriber Criteria Form

Demser 2026 PA Fax 2531-A v1 010126.docx  
Demser (metyrosine)  
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.  
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Demser (metyrosine).

Drug Name:  
Demser (metyrosine)

**Patient Name:**

**Patient ID:**

**Patient DOB:**

**Patient Phone:**

**Prescriber Name:**

**Prescriber Address:**

**City:**

**State:**

**Zip:**

**Prescriber Phone:**

**Prescriber Fax:**

**Diagnosis:**

**ICD Code(s):**

**Please circle the appropriate answer for each question.**

1	Is the requested drug being prescribed for ANY of the following: A) chronic treatment of a patient with malignant pheochromocytoma, B) preoperative preparation for surgery of a patient with pheochromocytoma, C) management of a patient with pheochromocytoma when surgery is contraindicated? [If no, then no further questions.]	Yes	No
2	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to an alpha-adrenergic antagonist?	Yes	No

Comments:

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

**Prescriber (or Authorized) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_