UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1450-1
Program	Prior Authorization/Notification
Medications	Demser® (metyrosine)
P&T Approval Date	7/2024
Effective Date	1/1/2025

1. Background:

Demser is indicated in the treatment of patients with pheochromocytoma for preoperative preparation of patients for surgery, management of patients when surgery is contraindicated, and the chronic treatment of patients with malignant pheochromocytoma. Demser is not recommended for the control of essential hypertension.

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Demser** will be approved based on the following criterion:

   a. Diagnosis of pheochromocytoma

Authorization will be issued for 12 months.

B. Reauthorization

1. **Demser** will be approved based on the following criterion:

   a. Documentation of positive clinical response to therapy

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4. References:

1. Demser [package insert]. Bridgewater, NJ: Bausch Health, LLC; July 2021.

Program	Prior Authorization/Notification – Demser
Change Control	
7/2024	New program.