Updated: 07/2020
DMMA Approved: 08/2020

Request for Prior Authorization for Isturisa (osilodrostat)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Isturisa (osilodrostat) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Isturisa (osilodrostat) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of Cushing's disease and the following criteria is met:

- Member must be 18 years of age or older
- Must be prescribed by or in association with an endocrinologist
- Member must have Cushing's syndrome that is persistent or recurrent as evidenced by ALL of the following:
    - mUFC > 1.3 x ULN [Mean of three 24-hour urine samples collected preferably on 3 consecutive days, during screening after washout of prior medical therapy for CD (if applicable)] with ≥ 2 of the individual UFC values being > 1.3 x ULN.
    - Morning plasma ACTH above Lower Limit of Normal.
    - Confirmation (based on medical history) of pituitary source of excess
- Member must have excessive secretion of adrenocorticotropin hormone (ACTH) by a pituitary tumor as evidenced by at least ONE of the following:
    - Histopathologic confirmation of an ACTH-staining adenoma in patients who have had prior pituitary surgery.
    - MRI confirmation of pituitary adenoma > 6 mm OR Bilateral inferior petrosal sinus sampling (BIPSS) with either CRH or DDAVP stimulation for patients with a tumor ≤ 6mm.
- Must provide documentation that pituitary surgery is not an option or has not been curative
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Member must have mUFC within normal limits (reference range must be provided).
- **Reauthorization Duration of Approval:** 12 months

HIGHMARK. Delaware HEALTH OPTIONS

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Isturisa (osilodrostat)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: ☐ Cushing's disease ☐ Other: _____

1. Is the member 18 years of age or older? ☐ Yes ☐ No
2. Is the medication prescribed by or in association with an endocrinologist? ☐ Yes ☐ No
3. Does the member have Cushing's syndrome that is persistent or recurrent as evidenced by ALL of the following?
   ☐ Yes ☐ No
   a. mUFC > 1.3 x ULN [Mean of three 24-hour urine samples collected preferably on 3 consecutive days, during screening after washout of prior medical therapy for CD (if applicable)] with ≥ 2 of the individual UFC values being > 1.3 x ULN.
   b. Morning plasma ACTH above Lower Limit of Normal.
   c. Confirmation (based on medical history) of pituitary source of excess

4. Does the member must have excessive secretion of adrenocorticotropin hormone (ACTH) by a pituitary tumor as evidenced by at least ONE of the following:

   a. Histopathologic confirmation of an ACTH-staining adenoma in patients who have had prior pituitary surgery
      ☐ Yes ☐ No

b. MRI confirmation of pituitary adenoma > 6 mm OR Bilateral inferior petrosal sinus sampling (BIPSS) with either CRH or DDAVP stimulation for patients with a tumor ≤ 6mm.
☐ Yes ☐ No

5. Does member have documentation that pituitary surgery is not an option or has not been curative? Please attach.
☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY			
Medication Name	**Strength/ Frequency**	**Dates of Therapy**	**Status (Discontinued & Why/Current)**

REAUTHORIZATION

Does member have mUFC within normal limits (reference range must be provided)? ☐ Yes ☐ No
Please provide value and attach documentation:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date