

SENTARA COMMUNITY PLAN (MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

Drug Requested: Isturisa[®] (osilodrostat)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Quantity Limits: 120 tablets per 30 days (1 mg & 5 mg tabs)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ☐ Member must be 18 years of age or older
- ☐ Provider is an endocrinologist or neurosurgeon
- ☐ Member has **ONE** of the following diagnoses:
 - ☐ Endogenous Cushing's Syndrome
 - ☐ Cushing's Disease

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- ☐ Member must meet at least **ONE** of the following (**chart notes must be submitted to document diagnosis and surgical history or contraindication to surgery**):
 - ☐ Member is **NOT** a candidate for surgery or surgery has **NOT** been curative
 - ☐ Member is awaiting surgery for endogenous Cushing's syndrome
- ☐ Member must have failed **90 days** of therapy with **ONE** of the following medications (**verified by chart notes or pharmacy paid claims**):
 - ☐ ketoconazole
 - ☐ metyrapone
 - ☐ mitotane
- ☐ Member must have current mean urine free cortisol levels (mUFC) > 3 times the upper limit of normal (ULN)
- ☐ Member will **NOT** use concurrent Cushing's disease treatment with Isturisa® (e.g., ketoconazole, metyrapone, mifepristone, mitotane)
- ☐ Member has been assessed for QTc prolongation/Torsade de Pointes, hepatic and renal impairment
- ☐ Member is **NOT** taking glucocorticoids (e.g., prednisone, hydrocortisone)
- ☐ For members with diabetes and/or hypertension, disease is adequately controlled
- ☐ Member does **NOT** have a history of any of the following:
 - Congestive Heart Failure (CHF)
 - Unstable angina
 - Sustained ventricular tachycardia
 - Clinically significant bradycardia
 - Advanced heart block
 - Acute myocardial infarction <1 year prior to starting Isturisa
 - Clinically significant impairment in cardiovascular disease

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ☐ Member's current 24-hour urinary free cortisol level is below the upper limit of normal (**labs must be submitted**)
- ☐ Improvements in quality of life have been maintained while on Isturisa® therapy
- ☐ Member will continue to be monitored for QTc prolongation, hepatic and renal impairment

Medication being provided by Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****