AvMed

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 1-305-671-0200**. 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 AvMed #: _____ **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 Name/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.

***Approved by Pharmacy and Therapeutics Committee:** ~~10/22/2020;~~ **5/22/2025**
REVISED/UPDATED/REFORMATTED: ~~12/7/2020; 8/11/2021; 6/16/2022;~~ **6/18/2025**