Mass General Brigham
Health Plan

Isturisa (osilodrostat)
Effective 05/01/2021

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit (NLX)		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview
Cushing disease is caused by a tumor or excess growth of the pituitary gland. In Cushing disease, the pituitary gland overstimulates production of ACTH and subsequent release of cortisol

Isturisa is indicated for the treatment of adult patients with Cushing disease for whom pituitary surgery is not an option or has not been curative.

Coverage Guidelines
Authorization may be reviewed for members new to the plan who are currently receiving treatment with Isturisa excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted for when documentation is provided for members who meet the following criteria:

1. The member has a diagnosis of Cushing disease
2. The member has had inadequate response or adverse reaction to one of the following or contraindication to ALL the following:
    a. Cabergoline
    b. Ketoconazole tablets
    c. Lysodren
3. The member has had inadequate response or adverse reaction to one of the following or contraindication to ALL the following:
    a. Signifor/Signifor LAR

Continuation of Therapy

Reauthorization may be granted when physician provides documentation that patient has lower urinary free cortisol levels since the start of the therapy or has improvement in signs and symptoms of the disease.

Limitations

1. Initial approvals will be granted for 6 months
2. Reauthorizations will be granted for 12 months.
3. The following quantity limits apply:

Isturisa 1mg	120 tablets per 30 days
Isturisa 5mg	60 tablets per 30 days
Isturisa 10mg	90 tablets per 30 days

References

1. Isturisa [package insert]. Lebanon, NJ: Recordati Rare Disease, Inc.; March 2020.

Review History

3/17/2021 – Created and Reviewed at March P&T. Effective 05/01/2021.