

**Isturisa (osilodrostat)**  
**Effective 05/01/2021**

<b>Plan</b>	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	<b>Program Type</b>	<input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
<b>Benefit</b>	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit		
<b>Specialty Limitations</b>	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
<b>Contact Information</b>	<b>Medical and Specialty Medications</b>		
	All Plans	Phone: 877-519-1908	Fax: 855-540-3693
<b>Exceptions</b>	<b>Non-Specialty Medications</b>		
	All Plans	Phone: 800-711-4555	Fax: 844-403-1029
<b>Exceptions</b>	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.

