Mass General Brigham
Health Plan

Isturisa (osilodrostat)
Effective 09/01/2025

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693		
	Non-Specialty Medications All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	N/A		

Overview
Isturisa (osilodrostat) is a cortisol synthesis inhibitor indicated for the treatment of endogenous hypercortisolemia in adults with Cushing's syndrome for whom surgery is not an option for has not been curative.

Coverage Guidelines
Authorization may be granted for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted when all of the following criteria have been met:

1. Member has a diagnosis of Cushing's syndrome
2. Requested medication is being used for treatment of endogenous hypercortisolemia
3. Member meets ONE of the following:
    a. Member is not a candidate for surgery (e.g., adrenalectomy, transsphenoidal surgery)
    b. Surgery has not been curative for the member
4. Member has had inadequate response, or adverse reaction or contraindication to ketoconazole

Continuation of Therapy
Requests for reauthorization will be approved when the following criteria are met:

1. Documentation the member has had a positive clinical response to therapy (e.g., clinically meaningful reduction in 24-hour urinary free cortisol levels, 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:

Drug Name and Dosage Form	Quantity Limitations
Isturisa 1 mg tablet	8 tablets per day
Isturisa 5 mg tablet	12 tablets per day

References

1. Isturisa (osilodrostat) [prescribing information]. Bridgewater, NJ: Recordati Rare Disease, Inc.; April 2025.

Review History

3/17/2021 – Created and Reviewed at March P&T. Effective 05/01/2021.
06/11/2025 – Reviewed and Updated at June P&T. Updated language for members who are new to the Plan. Updated criteria to reflect expanded indication. Criteria require member has a diagnosis of Cushing's syndrome and Isturisa is being used for endogenous hypercortisolemia. Member must either not be a candidate for surgery or have had an inadequate response to surgery. Updated previous trial requirements to require trial and failure with ketoconazole. Reauthorization criteria updates to require member has had a positive clinical response to therapy. Effective 09/01/2025.