

**Isturisa (osilodrostat)**  
**Effective 09/01/2025**

<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 Benefit</b> <b>Pharmacy Benefit</b>	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
<b>Exceptions</b>	N/A		

**Overview**

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

