Effective Date: 01/01/2021
Reviewed: 10/2020, 06/2021, 04/2022, 4/2023 Scope: Medicaid

Isturisa (osilodrostat)

POLICY

I. CRITERIA FOR APPROVAL

An authorization of 6 months may be granted when all the following criteria are met:

A. Member is 18 years of age or older, **AND**
B. Member has a documented diagnosis of Cushing's Disease, **AND**
C. Member has documentation of failed pituitary surgery or a contraindication to pituitary surgery, **AND**
D. Medication is prescribed by or in consultation with an endocrinologist, **AND**
E. Member has tried and failed OR had an intolerance or contraindication to Signifor or Signifor LAR

II. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for all members who meet all initial criteria and who have documentation of a positive clinical response after at least 6 months of therapy with Isturisa as evidenced by a mean urinary free cortisol level less than or equal to the upper limit of normal and improvement in overall signs and symptoms of the condition. Monitoring for severe adverse reactions such as hypocortisolism, QTc prolongation, or hypokalemia should continue routinely.

III. QUANTITY LIMIT

- 1mg tablet: 8 tablets/day
- 5mg tablet: 2 tablets/day
- 10mg tablet: 6 tablets/day

IV. COVERAGE DURATION

- 6 months

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