

HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

ISTURISA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: Isturisa® (osilodrostat)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the prescribing provider an endocrinologist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a confirmed diagnosis of persistent or recurrent Cushing's disease evidenced by at least three 24-hour mean urinary free cortisol (mUFC) > 1.5 times the upper of normal (ULN)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member shown symptoms of Cushing's Disease, such as diabetes, central obesity, moon face, buffalo hump, osteoporosis, muscle wasting, hypertension, depression and/or anxiety?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Is the member a candidate for pituitary surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. If the member has had pituitary surgery, was it NOT curative?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Has the member tried and failed, or has a contraindication/intolerance per FDA label to, Signifor® (pasireotide)? Note: Signifor® requires prior authorization	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. Has the member tried and failed, or has a contraindication/intolerance per FDA label to ketoconazole or Recorlev® (levoketoconazole)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
8. Does documentation include a baseline electrocardiogram (ECG)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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2. Does clinical documentation show a continued medical necessity, tolerability and efficacy of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does clinical documentation show a 24-hour urinary free cortisol below the upper limit of normal?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-CHIP-105
 Origination Date: 07/01/2024
 Reviewed/Revised Date:
 Next Review Date:
 Current Effective Date: 07/01/2024

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