HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
ISTURISA®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

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: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

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?	☐	☐	
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)?	☐	☐	**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?	☐	☐	**Please provide documentation**
4. Is the member a candidate for pituitary surgery?	☐	☐	**Please provide documentation**
5. If the member has had pituitary surgery, was it NOT curative?	☐	☐	**Please provide documentation**
6. Has the member tried and failed, or has a contraindication/intolerance to, Signifor®? Note: Signifor® requires prior authorization.	☐	☐	**Please provide documentation**
7. Does documentation include a baseline electrocardiogram (ECG)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. Does clinical documentation show a continued medical necessity, tolerability and efficacy of therapy?	☐	☐	**Please provide documentation**
3. Does clinical documentation show a 24-hour urinary free cortisol below the upper limit of normal?	☐	☐	**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:

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Policy: PHARM-105
Origination Date: 09/16/2020
Reviewed/Revised Date: 12/13/2021
Next Review Date: 12/13/2022
Current Effective Date: 01/01/2022