



UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

Program Number	2023 P 1318-4
Program	Prior Authorization/Notification
Medication	Isturisa <sup>®</sup> (osilodrostat)
P&T Approval Date	6/2020, 6/2021, 6/2022, 6/2023
Effective Date	9/1/2023; Oxford only: 9/1/2023

**1. Background:**

Isturisa (osilodrostat) is a cortisol synthesis inhibitor indicated for the treatment of adult patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative.

**2. Coverage Criteria<sup>a</sup>:**

**A. Initial Authorization**

1. **Isturisa** will be approved based on **both** of the following criteria:

a. Diagnosis of Cushing's disease

**-AND-**

b. **One** of the following:

(1) Patient is not a candidate for pituitary surgery

**-OR-**

(2) Pituitary surgery has not been curative

**Authorization will be issued for 12 months.**

**B. Reauthorization**

1. **Isturisa** will be approved based on the following criterion:

a. Documentation of positive response to Isturisa therapy

**Authorization will be issued for 12 months.**

<sup>a</sup> State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.



**3. Additional Clinical Rules:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply Limits may be in place

**4. References:**

1. Isturisa [Package Insert]. Lebanon, NJ: Recordati Rare Disease, Inc.; March 2020.

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<b>Change Control</b>	
6/2020	New program
6/2021	Annual review with no change to coverage criteria.
6/2022	Annual review with no change to clinical criteria.
6/2023	Annual review with no change to coverage criteria. Added state mandate footnote.