UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1318-5
Program	Prior Authorization/Notification
Medication	Isturisa® (osilodrostat)
P&T Approval Date	6/2020, 6/2021, 6/2022, 6/2023, 6/2024
Effective Date	9/1/2024

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[a]:

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.

[a] 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]. Bridgewater, NJ: Recordati Rare Disease, Inc.; November 2023.

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Change Control	
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.
6/2024	Annual review with no change to coverage criteria. Updated reference.