

Prior Authorization
JOHNS HOPKINS HEALTH PLANS (MEDICAID) Isturisa - Priority Partners MCO This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at 1-410-424-4607 . Please contact Johns Hopkins Health Plans at 1-888-819-1043 with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Isturisa - Priority Partners MCO.

Drug Name (select from list of drugs shown) Isturisa (osilodrostat)
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Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

Prescribing Physician	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

Diagnosis: _____	ICD Code: _____
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Comments: _____

Please circle the appropriate answer for each question.	
1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
[If yes, skip to question 9.]	
2. Does the patient have a diagnosis of Cushing's disease?	<input type="checkbox"/> Y <input type="checkbox"/> N

NOTE: Submission of medical records is required.	
[If no, no further questions.]	
3. Has the one of the following been submitted for the patient: A) persistent or recurrent disease despite pituitary surgery, or B) this is a new diagnosis of disease, and the patient is not a candidate for surgery?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
4. Is the mean of three 24-hour urinary free cortisol (UFC) levels at least 1.5 times the upper limit of normal measured?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
5. Does the patient have clinical symptoms of Cushing's disease (diabetes, moon face, buffalo hump, central obesity, muscle wasting, hypertension, depression, anxiety, etc.)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
6. Is the requested medication being prescribed by, or in consultation with, an endocrinologist?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
7. Does any of the following exclusions apply: A) the patient is pregnant or breast-feeding, B) the patient has clinical symptoms and profile due to adrenocorticotrophic hormone (ACTH) secretion, or ACTH-independent Cushing's syndrome (adrenal adenoma)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
8. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
9. Has the patient experienced beneficial response to treatment as evidenced by both of the following: A) a recent urinary free cortisol (UFC) level within normal limits, and B) improvement in the clinical symptoms of Cushing's disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date

