Priority Partners MCO
7231 Parkway Drive, Suite 100
Hanover, MD 21076

JOHNS HOPKINS MEDICINE

JOHNS HOPKINS HEALTHCARE

Prior Authorization

JOHNS HOPKINS HEALTHCARE (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 Healthcare at **1-410-424-4607**.
Please contact Johns Hopkins Healthcare 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)

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:** ____________________

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)?	Y 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?	Y 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?	Y 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?	Y 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.)?	Y 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?	Y 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 adrenocorticotropic hormone (ACTH) secretion, or ACTH-independent Cushing's syndrome (adrenal adenoma)?	Y N
	[If yes, no further questions.]	
8.	Is the patient 18 years of age or older?	Y 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?	Y 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