

Prior Authorization Request Form for osilodrostat (Isturisa)



JOHNS HOPKINS
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**FAX Completed Form and
Applicable Progress Notes to:
(410) 424-4037**

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 Please complete patient and physician information (please print):

<p>1 Patient Name: _____</p> <p>Address: _____</p> <p>Sponsor ID #: _____</p> <p>Date of Birth: _____</p>	<p>Physician Name: _____</p> <p>Address: _____</p> <p>Phone #: _____</p> <p>Secure Fax #: _____</p>
--	---

Step 2 Please complete the clinical assessment:

2 1. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Does the patient have a documented diagnosis of Cushing's disease?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Does the patient have persistent or recurrent Cushing's disease despite pituitary surgery?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Proceed to question 4
4. Is pituitary surgery not indicated in the patient?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Is the requested medication prescribed by an endocrinologist, oncologist, or neurosurgeon?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Does the provider agree to correct hypokalemia or hypomagnesemia prior to starting Isturisa, if applicable?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
7. Does the provider agree to obtain baseline electrocardiogram (ECG) prior to starting Isturisa?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved

Prior Authorization Request Form for osilodrostat (Isturisa)

8. Does the provider agree to use Isturisa with caution in patients with risk factors for QTc prolongation?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved
9. Will the patient be monitored closely for hypocortisolism and potentially life-threatening adrenal insufficiency? Note: Dosage reduction or interruption may be necessary	<input type="checkbox"/> Yes Proceed to question 10	<input type="checkbox"/> No STOP Coverage not approved
10. Will the patient be monitored for hypokalemia, worsening of hypertension, edema, and hirsutism?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

Step 3 I certify the above is true to the best of my knowledge.

Please sign and date:

_____ Prescriber Signature

_____ Date

[11 November 2020]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: