VENTURA COUNTY
HEALTH CARE PLAN

PRIOR AUTHORIZATION POLICY

POLICY: Cushing's – Isturisa Prior Authorization Policy
- Isturisa® (osilodrostat tablets – Recordati Rare Diseases)

REVIEW DATE: 04/09/2025; selected revision 04/30/2025

OVERVIEW
Isturisa, a cortisol synthesis inhibitor, is indicated for the **treatment of endogenous hypercortisolemia** in adults with **Cushing's syndrome** for whom pituitary surgery is not an option or has not been curative.[1]

Disease Overview
Cushing's syndrome refers to the general state of excessive levels of cortisol (hypercortisolism) in the blood.[2,3] Hypercortisolism can occur for reasons that are either endogenous or exogenous in nature (e.g., Cushing's disease, cortisol-containing medications, adrenal gland tumor, certain cancers). Cushing's disease (hypercortisolism caused by pituitary adenomas) is the most common type of adrenocorticotropic hormone (ACTH)-dependent Cushing's syndrome. Treatment for Cushing's syndrome requires a multi-modal approach. The goals of treatment are normalization of cortisol excess, long-term disease control, avoidance of recurrence, and reversal of clinical features.[4]

Guidelines
The Endocrine Society published clinical practice guidelines (2015) for the treatment of Cushing's syndrome.[5] Isturisa is not addressed in the guidelines. First-line treatment involves resection of the tumor, unless surgery is not possible or is unlikely to meaningfully reduce excess glucocorticoid levels. In patients with ACTH-dependent Cushing's syndrome who underwent non-curative surgery or for whom surgery was not possible, the guidelines advocate several second-line therapies (e.g., repeat transsphenoidal surgery, radiotherapy, medical therapy, and bilateral adrenalectomy). For Cushing's disease, the guidelines recommend all medical therapies as second-line options after transsphenoidal surgery: steroidogenesis inhibitors (ketoconazole tablets, Metopirone® [metyrapone capsules], Lysodren® [mitotane tablets], etomidate injection) in patients either with or without radiotherapy/radiosurgery; pituitary-directed medical treatments (cabergoline tablets, Signifor® [pasireotide subcutaneous injection]) in patients who are not surgical candidates or who have persistent disease; and mifepristone tablets (Korlym®, generic) in patients with diabetes or glucose intolerance who are not surgical candidates or who have persistent disease after transsphenoidal surgery.

POLICY STATEMENT
Prior Authorization is recommended for prescription benefit coverage of Isturisa. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Isturisa as well as the monitoring required for adverse events and long-term efficacy, approval requires Isturisa to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Isturisa is recommended in those who meet the following criteria:

FDA-Approved Indication

1. **Endogenous Cushing's Syndrome.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   Note: Cushing's disease is included in endogenous Cushing's syndrome.
   A) Patient is ≥ 18 years of age; AND
   B) Patient meets ONE of the following (i, ii, or iii)
      i. According to the prescriber, the patient is not a candidate for surgery or surgery has not been curative; OR
      ii. Patient is awaiting surgery for endogenous Cushing's syndrome; OR
      iii. Patient is awaiting therapeutic response after radiotherapy for endogenous Cushing's syndrome; AND
   C) The medication is prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of endogenous Cushing's syndrome.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Isturisa is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Isturisa® tablets [prescribing information]. Lebanon, NJ: Recordati Rare Diseases; April 2025.
2. Sharma ST, Nieman LK, Feelders RA. Cushing's syndrome: epidemiology and developments in disease management. *Clin Epidemiol*. 2015;7:281–293.
3. Tritos NA, Biller BM. Advances in medical therapies for Cushing's syndrome. *Discov Med*. 2012;13(69):171-179.
4. Biller BMK, Grossman AB, Stewart PM, et al. Treatment of adrenocorticotropin-dependent Cushing's syndrome: A consensus statement. *J Clin Endocrinol Metab*. 2008;93:2454-2462.
5. Nieman LK, Biller BM, Findling JW. Treatment of Cushing's Syndrome: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2015;100(8):2807-2831.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	06/14/2023
Early Annual Revision	**Endogenous Cushing's Syndrome:** A patient who is awaiting surgery and a patient who is awaiting therapeutic response after radiotherapy were added as options of approval; for these conditions (patient who is awaiting surgery and a patient who is awaiting therapeutic response after radiotherapy) a requirement was added that the patient has tried one other medication or the patient is currently receiving Isturisa. **Endogenous Cushing's Syndrome – Patient Awaiting Surgery:** This condition was removed from the policy and is now addressed under Endogenous Cushing's Syndrome. **Endogenous Cushing's Syndrome – Patient Awaiting Therapeutic Response After Radiotherapy:** This condition was removed from the policy and is now addressed under Endogenous Cushing's Syndrome.	04/19/2024
Annual Revision	No criteria changes.	04/09/2025

Selected Revision	**Endogenous Cushing's Syndrome:** This condition was moved from "Other Uses with Supportive Evidence" to "FDA-Approved Indication". The requirement for a trial of one previous therapy was removed. A note was added that "Cushing's disease is included in endogenous Cushing's syndrome." **Cushing's Disease:** This condition was removed as a separate condition of approval and will be addressed under the broader condition of approval of Endogenous Cushing's Syndrome.	04/30/2025