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# 5.30.066

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<b>Section:</b>	Prescription Drugs	<b>Effective Date:</b>	October 1, 2024
<b>Subsection:</b>	Endocrine and Metabolic Drugs	<b>Original Policy Date:</b>	April 3, 2020
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**Last Review Date:** September 6, 2024

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## Isturisa

### Description

#### Isturisa (osilodrostat)

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#### Background

Isturisa (osilodrostat) is a cortisol synthesis inhibitor. It inhibits 11 $\beta$ -hydroxylase (CYP11B1), the enzyme responsible for the final step of cortisol biosynthesis in the adrenal gland. Cushing's disease is caused by a tumor on the pituitary gland that results in high levels of the steroid hormone cortisol (1).

#### Regulatory Status

FDA-approved indication: Isturisa 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 (1).

Correct hypokalemia and hypomagnesemia prior to starting Isturisa. Baseline electrocardiogram (ECG) should be obtained. Repeat ECG should be done one week after initiation of treatment, and as clinically indicated thereafter (1).

Isturisa lowers cortisol levels and can lead to hypocortisolism and sometimes life-threatening adrenal insufficiency. Patients should be educated on the symptoms associated with hypocortisolism. 24-hour urine free cortisol, serum or plasma cortisol, and patient's signs and symptoms should be monitored periodically during Isturisa treatment (1).

Isturisa is associated with a dose-dependent QT interval prolongation which may cause cardiac arrhythmias. It is recommended to obtain a baseline QTc interval measurement prior to initiating

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therapy and monitoring periodically during treatment. If indicated, electrolyte abnormalities should be corrected (1).

The safety and effectiveness of Isturisa in pediatric patients less than 18 years of age have not been established (1).

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### Related policies

Korlym, Signifor, Signifor LAR

### Policy

*This policy statement applies to clinical review performed for pre-service (Prior Approval, Precertification, Advanced Benefit Determination, etc.) and/or post-service claims.*

Isturisa may be considered **medically necessary** if the conditions indicated below are met.

Isturisa may be considered **investigational** for all other indications.

## Prior-Approval Requirements

**Age** 18 years of age or older

### Diagnosis

Patient must have the following:

Cushing's disease

**AND ALL** of the following:

- Pituitary surgery was not curative, or patient is not a candidate for surgery
- Baseline electrocardiogram (ECG) has been or will be obtained, and prescriber agrees to monitor for QTc prolongation
- If indicated, hypokalemia and hypomagnesemia will be corrected prior to initiating therapy
- Prescriber agrees to monitor cortisol levels
- Prescriber agrees to monitor for hepatic impairment

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## Prior – Approval *Renewal* Requirements

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**Age** 18 years of age and older

## Diagnosis

Patient must have the following:

Cushing's disease

**AND ALL** of the following:

- Prescriber agrees to monitor for QTc prolongation
- Prescriber agrees to monitor cortisol levels
- Prescriber agrees to monitor for hepatic impairment

## Policy Guidelines

### Pre - PA Allowance

None

### Prior - Approval Limits

**Duration** 12 months

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### Prior – Approval *Renewal* Limits

Same as above

## Rationale

### Summary

Isturisa (osilodrostat) is a cortisol synthesis inhibitor. Cushing's disease is caused by a pituitary tumor that causes the release of too much of a hormone called adrenocorticotropin, which stimulates the adrenal gland to produce an excessive amount of cortisol. The safety and effectiveness of Isturisa in pediatric patients less than 18 years of age have not been established (1).

Prior approval is required to ensure the safe, clinically appropriate, and cost-effective use of Isturisa while maintaining optimal therapeutic outcomes.

### References

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1. Isturisa [package insert]. Lebanon, NJ: Recordati Rare Disease, Inc.; November 2023.

## Policy History

Date	Action
April 2020	Addition to PA
June 2020	Annual review
September 2020	Annual review
June 2021	Annual review
June 2022	Annual editorial review
December 2022	Annual review. Changed policy number to 5.30.066
June 2023	Annual review
June 2024	Annual review and reference update
September 2024	Annual review

## Keywords

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**This policy was approved by the FEP® Pharmacy and Medical Policy Committee on September 6, 2024 and is effective on October 1, 2024.**