Pharmacy Drug Policy Checklist

POLICY NAME	Isturisa (osilodrostat)	POLICY #	2839P

Criteria

Coverage Criteria for Cushing's Disease

- ☐ **1.1** Diagnosis of Cushing's Disease
- ☐ **1.2** Diagnosis of type 2 diabetes mellitus or documented glucose intolerance with supporting test results
- ☐ **1.3** Documentation that the member underwent a surgical procedure which was not curative or that the member is not a candidate for surgery
- ☐ **1.4** Age 18 years or older
- ☐ **1.5** Ordered by, or in consultation with an endocrinologist (hormone doctor)