UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1318-7
Program	Prior Authorization/Notification
Medication	Isturisa® (osilodrostat)
P&T Approval Date	6/2020, 6/2021, 6/2022, 6/2023, 6/2024, 6/2025, 6/2026
Effective Date	9/1/2026

1. Background:

Isturisa (osilodrostat) is a cortisol synthesis inhibitor indicated for the treatment of endogenous hypercortisolemia in adults with Cushing's syndrome for whom surgery is not an option or has not been curative.

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Isturisa** will be approved based on **both** of the following criteria:

   a. Diagnosis of Cushing's syndrome

   -AND-

   b. **One** of the following:

      (1) Patient is not a candidate for pituitary surgery

      -OR-

      (2) Pituitary surgery has not been curative

   Authorization will be issued for 12 months.

B. Reauthorization

1. **Isturisa** will be approved based on the following criterion:

   a. Documentation of positive response to Isturisa therapy

   Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

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3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply Limits may be in place

4. References:

1. Isturisa [Package Insert]. Bridgewater, NJ: Recordati Rare Disease, Inc.; November 2025.

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Change Control	
6/2020	New program
6/2021	Annual review with no change to coverage criteria.
6/2022	Annual review with no change to clinical criteria.
6/2023	Annual review with no change to coverage criteria. Added state mandate footnote.
6/2024	Annual review with no change to coverage criteria. Updated reference.
6/2025	Annual review. Updated nomenclature with no change to clinical intent. Update background and reference.
6/2026	Annual review with no change to coverage criteria. Updated reference.

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