AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Isturisa	Page:	1 of 2
Effective Date:	5/26/2026	Last Review Date:	4/2026

Applies to:	☒Illinois	☐Florida	☒Florida Kids
	☒New Jersey	☒Maryland	☐Michigan
	☒Pennsylvania Kids	☐Virginia	☐KY PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Isturisa under the patient's prescription drug benefit.

Description:

FDA-approved Indications[1]

Isturisa is indicated for the treatment of endogenous hypercoritsolemia in adult patients with Cushing's syndrome for whom pituitary surgery is not an option or has not been curative.

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Isturisa

Policy/Guideline:

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

- For initial requests, pretreatment cortisol level as measured by one of the following tests:
    - Urinary free cortisol (UFC)
    - Late-night salivary cortisol (LNSC)
    - 1 mg overnight dexamethasone suppression test (DST)
    - Longer, low dose DST (2 mg per day for 48 hours)
- For continuation of therapy requests (if applicable), laboratory report indicating current cortisol level has decreased from baseline as measured by one of the following tests:
    - Urinary free cortisol (UFC)
    - Late-night salivary cortisol (LNSC)
    - 1 mg overnight dexamethasone suppression test (DST)
    - Longer, low dose DST (2 mg per day for 48 hours)

Coverage Criteria

Cushing's Syndrome/Disease[1,2]

Authorization of 6 months may be granted for treatment of Cushing's syndrome/disease in members who either have had surgery that was not curative OR for members who are not candidates for surgery.

Continuation of Therapy

Cushing's Syndrome/Disease[1,2]

Authorization of 12 months may be granted for members that meet one of the following criteria:

- Lower cortisol levels since the start of therapy per one of the following tests:
  - Urinary free cortisol (UFC)
  - Late-night salivary cortisol (LNSC)
  - 1 mg overnight dexamethasone suppression test (DST)
  - Longer, low dose DST (2 mg per day for 48 hours)
- Improvement in signs and symptoms of the disease

Approval Duration and Quantity Restrictions:

Approval:

- Initial: 6 months; renewal: 12 months

Quantity Limits:

- Isturisa (osilodrostat) 1 mg tablet (a carton contains three blister packs of 20 tablets): 240 tablets per 30 days
- Isturisa (osilodrostat) 5 mg tablet (a carton contains three blister packs of 20 tablets): 360 tablets per 30 days

References:

1. Isturisa [package insert]. Bridgewater, NJ: Recordati Rare Diseases, Inc.; April 2025.
2. Fleseriu M, Auchus R, Bancos I, et al. Consensus on Diagnosis and Management of Cushing's Disease: A Guideline Update. Lancet Diabetes Endocrinol. 2021;9(12):847-875. doi:10.1016/S2213-8587(21)00235-7