CareSource Rxinnovations

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT AGENTS FOR CUSHING'S SYNDROME PRIOR AUTHORIZATION REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Non-Urgent ☐ Urgent ☐

Note: This form must be completed by the prescribing provider.

*****All sections must be completed or the request will be returned.*****

Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Prescriber's Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of Service: _____ Start Date: _____

Requested Medication & Strength	Quantity	Directions for Use

Duration of Therapy:

Is the patient currently receiving this therapy? ☐ Yes ☐ No

If yes, please note the Start Date: ☐☐ / ☐☐ / ☐☐☐☐

Physician Signature: _____ **Date:** _____

PA Requirements for Isturisa (osilodrostat phosphate)

1. Member is ≥18 years of age? ☐ Yes ☐ No
2. Diagnosis of Cushing's syndrome not treatable by or responsive to pituitary surgery? ☐ Yes ☐ No
   Diagnosis Code: _____
3. Member is currently utilizing pimozide (contraindicated)? ☐ Yes ☐ No
4. Dose requested is 60 mg/day or less? ☐ Yes ☐ No

PA Requirements for Korlym (mifepristone)

1. Member is ≥18 years of age? □ Yes □ No
2. Diagnosis of hyperglycemia secondary to endogenous Cushing's syndrome in patients who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not a candidate for surgery? □ Yes □ No Diagnosis Code: _____
3. Member is currently utilizing any of the following contraindicated agents: simvastatin, lovastatin, CYP3A substrates with narrow therapeutic ranges (e.g. cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, tacrolimus, etc.), systemic corticosteroids being utilized for life saving purposes (e.g., immunosuppression following organ transplant)? □ Yes □ No
4. Member has been diagnosed with any of the following contraindications to therapy: women with a history of unexplained vaginal bleeding, endometrial hyperplasia with atypia, or endometrial carcinoma? □ Yes □ No
5. Member has had a negative pregnancy test in the past 30 days? □ Yes □ No
   Date of negative pregnancy test (include documentation): _____
6. Prescriber has counseled member on risks associated with conceiving while utilizing mifepristone and appropriate methods of non-hormonal contraception? □ Yes □ No
7. Dose requested is 1200 mg/day or less? □ Yes □ No

PA Requirements for Lysodren (mitotane)

1. Please select member's diagnosis:
   - ☐ Cushing's syndrome Diagnosis Code: _____
   - ☐ Inoperable adrenocortical cancer Diagnosis Code: _____
2. Member is ≥ 18 years of age? ☐ Yes ☐ No
3. Member has had a negative pregnancy test in the past 30 days? ☐ Yes ☐ No
   Date of negative pregnancy test (include documentation): _____
4. Dose requested is 10 g/day or less? ☐ Yes ☐ No

PA Requirements for Metopirone (metyrapone)

1. Please select member's diagnosis
   - ☐ Cushing's syndrome Diagnosis Code: _____
   - ☐ Pituitary-dependent hypercortisolism Diagnosis Code: _____
   - ☐ Requiring diagnostic testing of HPA hormone function Diagnosis Code: _____
2. Member is ≥ 18 years of age (for all indications except diagnostic testing)? ☐ Yes ☐ No
3. Dose requested is 6 g/day or less? ☐ Yes ☐ No

PA Requirements for Recorlev (levoketoconazole)

1. Member is ≥ 18 years of age? □ Yes □ No
2. Diagnosis of hypercortisolemia in patients with Cushing's syndrome who have failed results from surgery or cannot have surgery □ Yes □ No Diagnosis Code: _____
3. Dose requested is 1.2 g/day or less □ Yes □ No

PA Requirements for Signifor (pasireotide diaspartate)

1. Please select member's diagnosis: Diagnosis Code: _____
   - ☐ Cushing's syndrome not treatable by or unresponsive to pituitary surgery
   - ☐ Prevention of post-operative pancreatic fistula, leak, or abscess in patients undergoing pancreaticoduodenectomy or distal pancreatectomy
2. Member is ≥ 18 years of age? ☐ Yes ☐ No
3. Dose requested is 2.4 mg/day or less? ☐ Yes ☐ No

PA Requirements for Signifor LAR (pasireotide pamoate)

1. Please select member's diagnosis: Diagnosis code: _____
   - ☐ Cushing's syndrome not treatable by or unresponsive to pituitary surgery
   - ☐ Acromegaly with inadequate response to surgery or surgery is not an option
   - ☐ Carcinoid syndrome inadequately controlled with first-generation somatostatin analog
2. Member is ≥ 18 years of age? ☐ Yes ☐ No
3. Dose requested is one of the following:
   a. 40 mg every 4 weeks for the diagnosis of Cushing's syndrome ☐ Yes ☐ No
   b. 60 mg every 4 weeks for the diagnosis of acromegaly or carcinoid syndrome ☐ Yes ☐ No