Print Reset

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATION ISTURISA® (osilodrostat) and RECORLEV® (levoketoconazole)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

ISTURISA® and RECORLEV® – to receive a 1-year approval for this drug, complete the following questions.

1. Is the prescriber a specialist in the area of the member's diagnosis (e.g., endocrinologist) or has the prescriber consulted with a specialist in the area of the member's diagnosis?

   ☐ Yes ☐ No

2. Is the member 18 years of age or older?

   ☐ Yes ☐ No

3. Does the member have a diagnosis of endogenous Cushing's syndrome (hypercortisolemia)?

   ☐ Yes ☐ No

4. Does the member meet one of the following conditions:

   a. The member is **not** a candidate for surgical treatment of Cushing's syndrome; **OR**

   b. The member has undergone surgery for Cushing's syndrome and the procedure was not curative?

   ☐ Yes ☐ No

5. Has the member received an ECG to establish a baseline QTc interval, and will periodic monitoring be performed? **Note**: Isturisa and Recorlev are associated with dose-related QT interval prolongation.

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

For RECORLEV:

6. Does the member have cirrhosis, acute liver disease, poorly controlled chronic liver disease, recurrent symptomatic cholelithiasis, a prior history of drug-induced liver injury from ketoconazole or any azole antifungal requiring treatment discontinuation, or extensive metastatic liver disease?

   ☐ Yes ☐ No

For renewal, complete the following questions to receive a 1-year approval:

7. Does the member continue to meet the above criteria (questions 1 through 5 for Isturisa and questions 1 through 6 for Recorlev)?

   ☐ Yes ☐ No

8. Does the member continue to experience clinical benefit from the requested treatment?

   ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process. Submission of documentation does NOT guarantee coverage.