Pharmacy Medical Necessity Guidelines: Cushing's Disease Agents

Effective: July 20, 2020

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM

These pharmacy medical necessity guidelines apply to the following:

Commercial Products

☒ Tufts Health Plan Commercial products – large group plans
☒ Tufts Health Plan Commercial products – small group and individual plans
☒ Tufts Health Freedom Plan products – large group plans
☒ Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Tufts Health Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:

RXUM: 617.673.0988

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Isturisa (osilodrostat) is a cortisol synthesis inhibitor indicated for the treatment of adult patients with Cushing's disease for whom primary surgery is not an option or has not been curative.

Korlym (mifepristone) is a cortisol receptor blocker indicated to control hyperglycemia secondary to hypercortisolism in adult patients with endogenous Cushing's syndrome who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery. Korlym (mifepristone) should not be used in the treatment of patients with type 2 diabetes unless it is secondary to Cushing's syndrome.

Signifor (pasireotide) is a somatostatin analog indicated for the treatment of adult patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative.

Cushing's disease is a rare, aggressive endocrine condition that is caused by an ACTH-secreting pituitary adenoma. Cushing's disease can occur spontaneously in children and adults, and it typically occurs after puberty with similar frequency in males and females. Most adults are diagnosed between 25 years of age and 45 years of age.

In Cushing's disease, the pituitary adenoma produces excessive ACTH causing adrenal hyperplasia and excessive cortisol production. The normal cortisol feedback mechanism of the hypothalamic-pituitary-adrenal (HPA) axis is interrupted, with loss of circadian rhythm and hypercortisolism. Cushing's disease is the most frequent cause of Cushing's syndrome. Complications associated with exposure to excess endogenous glucocorticoids (hypercortisolism) can include obesity, diabetes mellitus, dyslipidemia, hypertension, hypercoagulability, increased risk for infection, bone demineralization which can increase the risk for fracture, depression, cognitive impairment, respiratory complications, severe fatigue and muscle weakness, purplish skin striae, easy bruising, hyperpigmentation, loss of libido, hirsutism, acne, and menstrual disorders. The condition results in significant morbidity and mortality.

The goals of treatment of ACTH-dependent Cushing's syndrome include reversal of clinical features, normalization of biochemical changes with minimal morbidity, and long-term control without recurrence. Treatment of Cushing's syndrome is almost always surgical, and targets the site of pathologic hormone overproduction. The treatment of choice is trans-sphenoidal surgery in Cushing's disease. In patients with microadenomas, the remission rate is between 65% and 90% for those that undergo trans-sphenoidal surgery. However, the remission rate is lower (<65%) for patients with macroadenomas. Despite initial cure, up to 25% of patients will experience a recurrence within 10 years and a second surgery can be performed in selected cases. Radiation therapy is an alternative treatment option that can be considered in patients with remnant or recurrent disease.

Generally, the treatment of choice for Cushing's syndrome is curative surgery with selective pituitary or ectopic corticotrophin tumor resection. Second-line treatments include more radical surgery, radiation therapy (for Cushing's disease), medical therapy, and bilateral adrenalectomy.

Medical therapy is often required when surgery is delayed, contraindicated, or unsuccessful.

COVERAGE GUIDELINES

Isturisa (osilodrostat)

The plan may authorize coverage of **Isturisa (osilodrostat)** for Members when all the following criteria are met, and limitations do not apply:

Initial Therapy

1. Documented diagnosis of Cushing's disease

AND

2. Documentation that pituitary surgery is not an option or has not been curative for the Member

AND

3. The prescribing physician is an endocrinologist

AND

4. Member is at least 18 years of age

Reauthorization Criteria

1. Documented diagnosis of Cushing's disease

AND

2. The prescribing physician is an endocrinologist

AND

3. Member is at least 18 year of age

AND

4. Documentation of a reduction in baseline 24-hour urinary free cortisol levels

Korlym (mifepristone)

The plan may authorize coverage of **Korlym (mifepristone)** for Members with hyperglycemia secondary to hypercortisolism when **all** the following criteria are met:

Initial Therapy

1. Documented diagnosis of Cushing's syndrome

AND

2. Documented diagnosis of Type 2 Diabetes or glucose intolerance

AND

3. The Member has failed surgery to treat the condition (e.g., pituitary surgery, adrenal surgery) or is not a candidate for this type of surgery

Reauthorization Criteria

1. Documentation provided from physician documenting efficacy in current progress notes

Signifor (pasireotide)

The plan may authorize coverage of **Signifor (pasireotide)** for Members when all the following criteria are met, and limitations do not apply:

Initial Therapy

1. Documented diagnosis of Cushing's disease

AND

2. Documentation that pituitary surgery is not an option or has not been curative for the Member

AND

3. The prescribing physician is an endocrinologist

AND

4. Member is at least 18 years of age

Reauthorization Criteria

1. Documented diagnosis of Cushing's disease

AND

2. The prescribing physician is an endocrinologist

AND

3. Member is at least 18 year of age

AND

4. Documentation of a reduction in baseline 24-hour urinary free cortisol levels

LIMITATIONS

- The plan does not cover Korlym (mifepristone) for the treatment of patients with type 2 diabetes that is not secondary to Cushing's syndrome.
- Korlym (mifepristone) will not be approved if administered concomitantly with simvastatin, lovastatin, or CYP3A substrates with narrow therapeutic ranges (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus and tacrolimus).
- Initial approval will be limited to 3 months. Reauthorization will be provided in 12-month intervals.
- The plan does not cover Signifor (pasireotide) for any conditions not listed in the Pharmacy Coverage Guidelines above, unless there is sufficient documentation of efficacy and safety in the published literature.
- Members new to the plan stable on a Cushing's Disease agent should be reviewed against Reauthorization Criteria.
- Coverage for Signifor (pasireotide) will be limited to 60 ampules per 30 days.

CODES

Medical billing codes may not be used for these medications. These medications must be obtained via the Member's pharmacy benefit.

REFERENCES

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APPROVAL HISTORY

August 14, 2012: Korlym Reviewed by Pharmacy & Therapeutics Committee: No subsequent changes

June 12, 2014: Signifor Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. June 9, 2015: No changes.
2. January 1, 2016: Administrative change to rebranded template.
3. June 14, 2016: No changes.
4. April 11, 2017: Administrative update. Effective 6/1/2017, Medical Necessity Guideline applies to Tufts Health RITogether.
5. June 13, 2017: No changes.
6. June 12, 2018: No changes.

7. February 12, 2019: No changes.
8. April 14, 2020: Effective July 1, 2020, modified reauthorization criteria and added the following Limitation: "Members new to the plan stable on Signifor (pasireotide) should be reviewed against Reauthorization Criteria." Updated coverage criteria to require a documented diagnosis of Cushing's disease.
9. July 14, 2020: Effective 7/20/20, Consolidated Korlym with Singnifor and added coverage criteria for Isturisa. Changed the name of the MNG to "Cushing's Disease Agents." Moved Korlym reauthorization criteria up to coverage criteria.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.