ISTURISA®
(Osilodrostat)
Patient Prescription Form

anovo SPECIALTY PHARMACY

Fax: 855-813-2039
Phone:888-855-RARE
(888-855-7273)

If your office has not received a confirmation fax that your referral has been received within 24 hours after submission, please refax or call AnovoRx at (888) 855-RARE (7273)

Please select one: **Newly Prescribed Patient** **Patient Currently on Isturisa®**

Patient Information
*Please print

Last Name:	First Name:	SSN:	Sex: M F
Address:	City:	State:	Zip:
Phone: Day #	Evening #:	Cell # :	
DOB:		Email:	
If Patient is a Minor, Guardian/Parent Name:		Relation to Patient:	
Emergency Contact:		Phone #:	

Insurance Information
*Complete this section or include copy of insurance card

Primary Insurance Co. Name:		Phone #:
Policy Holder Name:	Policy #:	Group #:
Prescription Card Name:		Phone #:
Policy #:		Group #:
Secondary Insurance Co. Name:		Phone #:
Policy Holder Name:	Policy #:	Group #:

Physician Information

Prescriber Name/Title:		
NPI:	Medicaid UPIN:	State License #:
Address:		
City:	State: Zip:	
Name of Contact Person:		Phone:
Physician/Office Contact Email:		Fax:

Prescription

ISTURISA® (Osilodrostat) tablets
(Prior authorizations may be needed by each strength)

1 mg tablet
5 mg tablet

SIG:
Take ____ mg 2 times per day.

Dispense 1 month ____ 3 months _____

Refills ________

Prescriber to specify any titration instructions here:

____

____

Medical Necessity

Primary diagnosis:	Date of Diagnosis :	Patient Age at Diagnosis:

Please check applicable ICD-10 code:

Cushing's Disease, pituitary-dependent (E24.0)

Cushing's Syndrome, unspecified (E24.9)

Other (please specify) ______________________________

Therapy Start Date ____________________

Clinical Background

Allergies ____ NKDA

Concurrent and Previously Prescribed, if any *(optional)*

Ketoconazole: Dose__________Frequency__________

Metyrapone: Dose__________Frequency__________

Cabergoline: Dose__________Frequency__________

Pasireotide: Dose__________Frequency__________ LAR Subcutaneous

Mifepristone: Dose__________Frequency__________

Other: ____________________________________

I certify I am prescribing ISTURISA® for this patient for a medically necessary purpose. **Date Written:** ____________________

Dispense as Written:________________________________
(Stamped Signatures Are Not Valid)

Substitution Allowed: ________________________________
(Stamped Signatures Are Not Valid)

This patient referral form is only valid if FAXED directly from the prescriber to Anovo @ 855-813-2039

Form: ISTURISA.RX.01
Effective Date: 02.10.20 Revision Date: 05.14.20, 10.21.20, 11.4.20, 11.25.20, 11.2.21,11.5.21, 6.20.23