anovo SPECIALTY PHARMACY

# ISTURISA®
# (Osilodrostat)
# Patient Prescription Form

**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