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
☐ 10 mg tablet

Prescriber to specify any titration instructions here:

SIG:
Take ____ mg 2 times per day.

Dispense 1 month ☐ 3 months ☐

Refills _____

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