STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

LEVOKETOCONAZOLE

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
LEVOKETOCONAZOLE	RECORLEV	47743		GPI-10 (3002204000)	

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Does the patient have a diagnosis of Cushing's syndrome and meet **ALL** of the following criteria?
   - The patient is 18 years of age or older
   - Therapy is prescribed by or in consultation with an endocrinologist
   - The patient is not a candidate for surgery or surgery has not been curative
   - The patient has tried or has a contraindication to oral ketoconazole

   If yes, **approve for 6 months by HICL or GPI-10 with a quantity limit of #8 per day.**
   If no, do not approve.
   INTIAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **LEVOKETOCONAZOLE (Recorlev)** requires the following rule(s) be met for approval:
   A. You have Cushing's syndrome (a type of hormone disorder)
   B. You are 18 years of age or older
   C. Therapy is prescribed by or in consultation with an endocrinologist (a type of hormone doctor)
   D. You are not a candidate for surgery or surgery has not been curative
   E. You have tried or have a contraindication (harmful for) to oral ketoconazole

   Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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LEVOKETOCONAZOLE

GUIDELINES FOR USE (CONTINUED)

RENEWAL CRITERIA

1. Does the patient have a diagnosis of Cushing's syndrome and meet **ALL** of the following criteria?
   - The patient continues to have improvement of Cushing's syndrome (e.g., clinically meaningful reduction in 24-hour urinary free cortisol and/or improvements in signs and symptoms of disease)
   - The patient maintains tolerability to Recorlev

   If yes, **approve for 12 months by HICL or GPI-10 with a quantity limit of #8 per day.**
   If no, do not approve.
   RENEWAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **LEVOKETOCONAZOLE (Recorlev)** requires the following rule(s) be met for renewal:
   A. You have Cushing's syndrome (a type of hormone disorder)
   B. You continue to have improvement of Cushing's syndrome (such as clinically meaningful reduction in 24-hour urinary free cortisol and/or improvements in signs and symptoms of your disease)
   C. You continue to tolerate treatment with Recorlev

   Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Recorlev.

REFERENCES

- Recorlev [Prescribing Information]. Chicago, IL: Xeris Pharmaceuticals, Inc.; January 2022.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 02/01/22
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