pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

KORLYM (mifepristone) PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this form. Incomplete documentation may delay the processing of this request.**
- Prior authorization guidelines may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Korlym** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Additional info ☐Renewal request (PA# _____)	# of pages in request: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Korlym 300 mg tablet	Dose/directions:	Quantity:	Refills:
Diagnoses (*submit documentation*):		Dx codes (*required*):	

Section A: INITIAL requests

1. Does the Recipient have a diagnosis of endogenous Cushing's syndrome?	☐Yes ☐No	*Submit documentation of diagnoses, including lab & other diagnostic test results.*
2. Does the Recipient have a diagnosis of type 2 diabetes or glucose intolerance?	☐Yes ☐No	
3. Is the Recipient a candidate for pituitary surgery, or has the Recipient failed pituitary surgery?	☐Yes ☐No	*Submit documentation of surgical evaluation or surgery outcomes.*
4. Does the Recipient have a history of trial & failure (as evidenced by an HbA1c of ≥ 8%), contraindication, or intolerance with maximum tolerated doses of the following? *Check all that apply.* ☐insulin ☐sulfonylurea ☐DPP-4 inhibitor ☐metformin ☐thiazolidinedione ☐GLP-1 receptor agonist	☐Yes ☐No	*Submit documentation of all drug regimens tried and treatment outcomes (including HbA1c levels), intolerances, and/or contraindications.*
5. Is the Recipient taking any medications that interact with Korlym, such as simvastatin, lovastatin, long-term corticosteroids, cyclosporine, fentanyl, quinidine, etc.?	☐Yes ☐No	*Submit Recipient's complete current medication list.*
6. *If the Recipient is female,* does she have any of the following contraindications to Korlym? *Check all that apply.* ☐history of unexplained vaginal bleeding ☐endometrial hyperplasia with atypia ☐endometrial carcinoma	☐Yes ☐No	*Submit supporting documentation.*
7. *If the Recipient is female*, check all of the following that apply and *submit supporting documentation.* ☐has been surgically sterilized ☐had a negative pregnancy test prior to starting Korlym ☐will be using non-hormonal contraception		

Section B: RENEWAL requests

1. Since starting Korlym, has the Recipient experienced improvement in glycemic control as evidenced by a recent HbA1c value?	☐Yes ☐No	*Submit documentation of recent HbA1c test results.*
2. Is the Recipient taking any medications that interact with Korlym, such as simvastatin, lovastatin, long-term corticosteroids, cyclosporine, fentanyl, quinidine, etc.?	☐Yes ☐No	*Submit Recipient's complete current medication list.*
3. *If the Recipient is female*, has she been surgically sterilized, or will she be using a form of non-hormonal contraception?	☐Yes ☐No	*Submit documentation of surgery or contraception methods used.*
4. *If the Recipient is female*, does she have any of the following contraindications to Korlym? *Check all that apply.* ☐currently pregnant ☐endometrial hyperplasia with atypia ☐history of unexplained vaginal bleeding ☐endometrial carcinoma	☐Yes ☐No	*Submit supporting documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: