

### 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		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name: _____		
<input type="checkbox"/> Renewal request	(PA# _____)				
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**

<b>Korlym 300 mg tablet</b>	Dose/directions: _____	Quantity: _____	Refills: _____
Diagnoses ( <i>submit documentation</i> ): _____		Dx codes ( <i>required</i> ): _____	

#### **Section A: INITIAL requests**

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

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

<b>Prescriber Signature:</b> _____	<b>Date:</b> _____
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