PRIOR AUTHORIZATION REQUEST
Korlym

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the indication or diagnosis?
   - ☐ Endogenous Cushing's syndrome
   - ☐ Exogenous (iatrogenic) Cushing's syndrome
   - ☐ Type 2 diabetes not associated with endogenous Cushing's syndrome
   - ☐ Psychotic features of psychotic depression
   - ☐ All other indications or diagnoses - Please specify _____
2. ☐ Yes ☐ No Has Korlym been prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome?
3. ☐ Yes ☐ No Is the patient awaiting therapeutic response after radiotherapy?
4. ☐ Yes ☐ No Is the patient awaiting surgery?
5. ☐ Yes ☐ No According to the prescriber, is the patient a candidate for surgery or has surgery been curative?
6. ☐ Yes ☐ No Is Korlym being used to control hyperglycemia secondary to hypercortisolism in a patient who has type 2 diabetes mellitus or glucose intolerance?
7. ☐ Yes ☐ No Is the patient currently receiving Korlym?
8. ☐ Yes ☐ No Has the patient tried ketoconazole tablets, Metopirone (metyrapone capsules), Lysodren (mitotane tablets), or Signifor/Signifor LAR for the treatment of Cushing's syndrome?

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

If you have any questions, call: 800-753-2851

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SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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