PRIOR AUTHORIZATION REQUEST

Korlym

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1 What is the diagnosis or indication?
[] Endogenous Cushing's syndrome (If checked, go to 2)

[] Type 2 diabetes not associated with endogenous Cushing's syndrome (If checked, no further questions)

[] Psychotic features of psychotic depression (If checked, no further questions)

[] All other indications or diagnoses (If checked, no further questions)

2 Is the patient greater than or equal to 18 year(s) of age? If yes, please specify age: _____ Yes No

If you have any questions, call: 1-888-258-8250

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	[If no, no further questions.]		
3	Has the requested medication been prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome? [If no, no further questions.]	Yes	No
4	Will the requested medication be used along with long term systemic steroids? [If yes, no further questions.]	Yes	No
5	Is the patient currently receiving the requested medication? [If no, skip to question 15.]	Yes	No
6	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 15.]	Yes	No
7	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 14.]	Yes	No
8	Has documentation been provided to confirm that the patient's condition has improved or stabilized based upon the prescriber's assessment while on therapy? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Has the patient's glycemic control (HbA1c) improved compared to baseline? [If no, no further questions.]	Yes	No
10	Has the patient been adherent to the requested medication? [If no, no further questions.]	Yes	No
11	Is the patient a male or female? [] Male (If checked, no further questions) [] Female (If checked, go to 12)		
12	Is the patient a woman of reproductive potential? [If no, no further questions.]	Yes	No
13	Has documentation been provided to confirm that the patient has a non-hormonal contraception plan? ACTION REQUIRED: Submit supporting documentation. [No further questions]	Yes	No
14	Does the provider have a documented clinical response of the member's condition which has stabilized or improved based upon the prescriber's assessment?	Yes	No

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	ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
15	Is the patient a male or female? [] Male (If checked, go to 20) [] Female (If checked, go to 16)		
16	Is the patient a woman of reproductive potential? [If no, skip to question 19.]	Yes	No
17	Has documentation been provided to confirm that the patient has a non-hormonal contraception plan? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
18	Has documentation been provided to confirm that the patient has negative pregnancy test prior to initiating therapy? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Will the requested medication be used in patients with a history of unexplained vaginal bleeding, endometrial hyperplasia with atypia or endometrial carcinoma? [If yes, no further questions.]	Yes	No
20	Is the patient awaiting therapeutic response after radiotherapy? [If no, skip to question 22.]	Yes	No
21	Has the patient undergone radiotherapy for treatment of endogenous Cushing's syndrome within the last 24 months? [If yes, skip to question 23.] [If no, no further questions.]	Yes	No
22	According to the prescriber, is the patient a candidate for surgery or has surgery been curative? [If yes, no further questions.]	Yes	No
23	Has documentation been provided to confirm the requested medication is used to treat high blood sugar (hyperglycemia) caused by high cortisol levels in the blood (hypercortisolism) in patients who have type 2 diabetes mellitus or glucose intolerance? ACTION REQUIRED: Submit supporting documentation. [NOTE: Documentation of glucose intolerance must be assessed by a 2 hour glucose tolerance test with plasma glucose value of 140 - 199 mg/dL, fasting serum glucose test, or HbA1c.] [If no, no further questions.]	Yes	No
24	Has documentation been provided to confirm that the patient has had intolerance, contraindication to or failed treatment with both insulin and metformin therapy or with at least two other oral diabetic therapies? ACTION REQUIRED: Submit	Yes	No

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	supporting documentation. [If no, no further questions.]		
25	Will the patient's drug regimen be assessed for any drug interactions or contraindications such as concurrent use with lovastatin, simvastatin, cyclosporine, fentanyl, tacrolimus, etc.?	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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