maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Recorlev

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is this request for initial therapy or for a continuation of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

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

Version 07.2025

PRIOR AUTHORIZATION REQUEST

3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved prior authorization (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 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [Note: Improvement of clinical symptoms of Cushing's syndrome and laboratory values showing improvement from baseline.] [No further questions.]	Yes	No
7	What is the diagnosis or indication? [] Endogenous hypercortisolemia due to Cushing's syndrome (If checked, go to 8) [] Other (If checked, no further questions)		
8	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
9	Does the patient have documentation supporting diagnosis of Cushing's syndrome? ACTION REQUIRED: Submit supporting documentation. [Note: Abnormal dexamethasone suppression test (DST) or 2 measurements of elevated late night salivary cortisol concentrations.] [If no, no further questions.]	Yes	No
10	Has documentation been submitted to confirm clinical symptoms of Cushing's syndrome? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Does the patient have documentation of pretreatment cortisol levels obtained within 90 days of this request? ACTION REQUIRED: Submit supporting documentation. [Note: Urinary free cortisol (UFC) -1.5x ULN.] [If no, no further questions.]	Yes	No
12	Is the patient a candidate for surgery? ACTION REQUIRED: Submit supporting documentation. [Note: rationale for not being a candidate is required.] [If no, skip to question 15.]	Yes	No
13	Did the patient have pituitary surgery? ACTION REQUIRED: Submit supporting	Yes	No

PRIOR AUTHORIZATION REQUEST

	documentation. [If no, no further questions.]		
14	Has documentation been submitted to show pituitary surgery was not curative? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Has documentation been submitted to show baseline laboratory testing obtained within 90 days of this request for the following: A) Liver tests (ALT/AST/total bilirubin), B) Electrocardiogram (ECG), C) Potassium, and D) Magnesium levels? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Has the patient been treated with mitotane within 6 months of this request? [If yes, no further questions.]	Yes	No
17	Does the patient have any clinical or radiological signs of compression of the optic chiasm? [If yes, no further questions.]	Yes	No
18	Does the patient have a contraindication to oral Ketoconazole tablets? [If yes, no further questions.]	Yes	No
19	Has the patient failed at least 90 days of therapy with maximally tolerated dosages of Ketoconzazole in the last 12 months? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 21.]	Yes	No
20	Has documentation been provided to confirm that the patient has experienced intolerance, adverse side effect, or treatment failure to Ketoconazole? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
21	Has the patient failed at least 90 days of therapy with Signifor/Signifor LAR in the last 12 months? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
22	Has documentation been provided to confirm that the patient has experienced intolerance, adverse side effect, or treatment failure to Signifor/Signifor LAR? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
23	Is the requested medication being prescribed by or in consultation with an endocrinologist? [If no, no further questions.]	Yes	No
24	Does the provider attest that Recorlev daily dosage of the requested medication will not exceed 1,200 mg?	Yes	No

PRIOR AUTHORIZATION REQUEST

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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Version 07.2025