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. 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 the request for an INITIAL or a CONTINUATION of therapy? [] Initial (If checked, go to 6) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 6.]	Yes	No
3	Has the patient been receiving medication samples of the requested medication?	Yes	No

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

PRIOR AUTHORIZATION REQUEST

	[If yes, skip to question 6.]		
4	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 6.]	Yes	No
5	Has the patient been taking the requested medication for AT LEAST 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
6	What is the diagnosis or indication? [] Endogenous Cushing's syndrome (If checked, go to 7) [] Other (If checked, no further questions)		
7	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
8	Is the requested medication being 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
9	Has documentation been provided to confirm that mifepristone is being used to control hyperglycemia secondary to hypercortisolism in patients who have type 2 diabetes mellitus or glucose intolerance? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Will the requested medication be used along with long term systemic steroids? [If yes, no further questions.]	Yes	No
11	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.? [If no, no further questions.]	Yes	No
12	Is the patient a male or female? [] Male (If checked, go to 17) [] Female (If checked, go to 13)		
13	Is the patient a woman of reproductive potential? [If no, skip to question 16.]	Yes	No
14	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

PRIOR AUTHORIZATION REQUEST

15	Has documentation been provided to confirm that the patient had a negative pregnancy test prior to initiating therapy? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	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
17	Is the patient awaiting therapeutic response after radiotherapy? [If no, skip to question 19.]	Yes	No
18	Has the patient undergone radiotherapy for treatment of endogenous Cushing's syndrome within the last 24 months? [If yes, skip to question 20.] [If no, no further questions.]	Yes	No
19	According to the prescriber, is the patient a candidate for surgery or has surgery been curative? [If yes, no further questions.]	Yes	No
20	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
21	Has documentation been provided to confirm that the patient has tried and failed BOTH insulin and metformin therapy or AT LEAST 2 other oral diabetic therapies unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
22	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 300 mg once daily.]	Yes	No

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

PRIOR AUTHORIZATION REQUEST

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.

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

Version 04.2026