pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

KORLYM (mifepristone) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Korlym (mifepristone)** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐ New request ☐ Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Korlym 300 mg tablet	Dose/directions:	Quantity:	Refills:
Diagnoses *(submit documentation)*:		Dx codes (*required*):	
If the beneficiary is female, does she have any of the following contraindications to Korlym? *Check all that apply.* ☐ currently pregnant ☐ endometrial hyperplasia with atypia ☐ history of unexplained vaginal bleeding ☐ endometrial carcinoma		☐ Yes ☐ No	*Submit supporting documentation.*
Is the beneficiary taking any medications that interact with Korlym, such as simvastatin, lovastatin, long-term corticosteroids, cyclosporine, fentanyl, quinidine, sirolimus, tacrolimus, ergotamine, etc.?		☐ Yes ☐ No	*Submit beneficiary's complete current medication list.*

INITIAL requests

Does the beneficiary have a diagnosis of endogenous Cushing's syndrome?	☐ Yes ☐ No	*Submit documentation of diagnoses, including lab & other diagnostic test results.*
Does the beneficiary have a diagnosis of type 2 diabetes or glucose intolerance?	☐ Yes ☐ No	
Is the beneficiary a candidate for pituitary surgery, or has the beneficiary failed pituitary surgery?	☐ Yes ☐ No	*Submit documentation of surgical evaluation or surgery outcomes.*
Does the beneficiary have a history of trial & failure (as evidenced by an HbA1c of ≥ 8%), contraindication, or intolerance with maximum tolerated doses of the following? ☐ insulin ☐ sulfonylurea ☐ DPP-4 inhibitor ☐ metformin ☐ thiazolidinedione ☐ GLP-1 receptor agonist	☐ Yes ☐ No	*Submit documentation of all drug regimens tried and treatment outcomes (including HbA1c levels), intolerances, and/or contraindications.*

If the beneficiary is female, check all of the following that apply and *submit supporting documentation.*
☐ has been surgically sterilized ☐ had a negative pregnancy test prior to starting Korlym ☐ will be using non-hormonal contraception

RENEWAL requests

Since starting Korlym, has the beneficiary experienced improvement in glycemic control as evidenced by a recent HbA1c value?	☐ Yes ☐ No	*Submit documentation of recent HbA1c test results.*
If the beneficiary is female, has she been surgically sterilized, or will she be using a form of non-hormonal contraception?	☐ Yes ☐ No	*Submit documentation of surgery or contraception methods used.*

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

Prescriber Signature:	Date: