KORLYM
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review
☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date):** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:

☐ Cushing's Syndrome
☐ Other (Please include ICD code plus description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. What is the patient's weight? _____ (kg)
2. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
   If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.** ☐ Yes ☐ No
3. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindications: _____
   _____
4. Is the patient's age within FDA labeling for the requested indication for the requested agent? ☐ Yes ☐ No
   If no, please provide support for using the requested agent for the patient's age for the requested indication: _____
   _____
5. Does the patient have type 2 diabetes mellitus? ☐ Yes ☐ No
   If no, does the patient have glucose intolerance as defined by a 2-hr glucose tolerance test plasma glucose value of 140-199 mg/dL? ☐ Yes ☐ No
6. Has the patient had an inadequate response to surgical resection? ☐ Yes ☐ No
   If no, is the patient a candidate for surgical resection? ☐ Yes ☐ No
7. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., endocrinologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ☐ Yes ☐ No
8. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____
   _____
   _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For brand Korlym requests:

- **Please submit chart notes to support the answers to the following questions:**

9. Has the patient tried and had an inadequate response to the generic equivalent (mifepristone) that is NOT expected to occur with the brand agent? ☐ Yes ☐ No
10. Was the generic equivalent (mifeprestone) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
11. Does the patient have an intolerance or hypersensitivity to the generic equivalent (mifepristone) that is NOT expected to occur with the requested agent? ☐ Yes ☐ No
12. Does the patient have an FDA labeled contraindication to the generic equivalent (mifepristone) that is NOT expected to occur with the requested agent? ☐ Yes ☐ No
13. Is the generic equivalent (mifepristone) expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? ☐ Yes ☐ No
14. Is the generic equivalent (mifepristone) NOT in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
15. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the generic equivalent (mifepristone) and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No

For all renewal requests:

16. Has the patient had clinical benefit with the requested agent? ☐ Yes ☐ No

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**

BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525