KORLYM® (mifepristone)
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.
By submitting this form, you attest that all information provided is true and accurate.

PLEASE NOTE: Incomplete forms will be returned for additional information.
To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com
For formulary information, please visit www.myprime.com

PATIENT AND INSURANCE INFORMATION **Today's date:** _____

Patient First Name:	Patient Last Name:		MI:	DOB (mm/dd/yyyy):
Patient Street Address:	City, State:		ZIP:	Patient Phone:
Member ID Number:	Group Number:			

PRESCRIBER/CLINIC INFORMATION

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

MEDICAL INFORMATION. PLEASE ATTACH ADDITIONAL INFORMATION AS NEEDED.

Patient Diagnosis with ICD-9 Code:	ICD-10 Code:
Medication and Strength Requested:	
Dosing Schedule:	Quantity per Month:

ALL REQUESTS

Please list the medications the patient has previously tried and failed for the treatment of this diagnosis:

_____ Date range: _____ _____ Date range:_____
_____ Date range: _____ _____ Date range:_____
_____ Date range: _____ _____ Date range:_____

Is the patient currently treated with the requested medication? ☐ Yes ☐ No

Please provide the patient's weight: _____ ☐ LBS ☐ KGS

INITIAL REQUESTS

Is the requested medication being used to treat hyperglycemia? ☐ Yes ☐ No

Has the patient been diagnosed with endogenous Cushing's syndrome? ☐ Yes ☐ No

Has the patient been diagnosed with type 2 diabetes mellitus? ☐ Yes ☐ No

Has the patient been diagnosed with glucose intolerance secondary to Cushing's syndrome? ☐ Yes ☐ No

Has the patient undergone and had an inadequate response to surgical treatment of hypercortisolism? ☐ Yes ☐ No

If no: Is the patient a candidate for surgical treatment of hypercortisolism? ☐ Yes ☐ No

Please continue to the next page.

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

RENEWAL REQUESTS

Has the patient been previously approved by Florida Blue, Truli, or another health plan in the past 2 years for hyperglycemia due to endogenous Cushing's syndrome? ..... ☐ Yes ☐ No

If no: Please also complete the Initial Requests section.

Has the patient demonstrated a beneficial response (improved or stable glucose tolerance) to treatment with requested medication? ..... ☐ Yes ☐ No

Please indicate:

☐ Date of service (if applicable): (mm/dd/yyyy): _____

☐ Start of treatment: Start date (mm/dd/yyyy): _____

☐ Continuation of therapy: Date of last treatment (mm/dd/yyyy): _____

What is the priority level of this request?

☐ Standard

☐ Urgent (NOTE: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

If yes: Please specify: _____

_____

Please fax or mail this form to:
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Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

TOLL FREE
FAX: 855.212.8110 PHONE: 888.271.3183