UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Korlym

Program	Prior Authorization
Medication	Korlym™ (mifepristone)
Markets in Scope	Arizona, California, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania- CHIP, Rhode Island, South Carolina
Issue Date	6/2012
Pharmacy and Therapeutics Approval Date	3/2020
Effective Date	5/2020

1. Background:

Korlym (mifepristone) is a cortisol receptor blocker indicated to control hyperglycemia secondary to hypercortisolism in adult patients with endogenous Cushing's syndrome who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery.

Korlym is not indicated for the treatment of type 2 diabetes mellitus unrelated to endogenous Cushing's syndrome.

2. Coverage Criteria:

A. Initial Authorization

1. **Korlym** will be approved based on **all** of the following criteria:

   a. Diagnosis of endogenous Cushing's syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids)

   -AND-

   b. **One** of the following:

      (1) Diagnosis of type 2 diabetes mellitus

      (2) Diagnosis of glucose intolerance

   -AND-

   c. **One** of the following:

      (1) Patient has failed surgery

(2) Patient is not a candidate for surgery

Authorization will be issued for 12 months.

B. Reauthorization

1. **Korlym** will be approved based on the following criterion:

   a. Documentation of **one** of the following:

      (1) Patient has improved glucose tolerance while on Korlym therapy

      (2) Patient has stable glucose tolerance while on Korlym therapy

Authorization will be issued for 12 months.

3. References:

1. Korlym [Package Insert]. Menlo Park, CA: Corcept Therapeutics, Inc.; November 2019.

Program	Prior Authorization –Korlym (mifepristone)
Change Control	
Date	Change
6/2012	New Guideline
6/2013	Converted policy to new UHC enterprise wide formatting. Removed age requirement. Removed requirement for trial of first and second line antidiabetic therapy Added prescriber requirement Added requirement that the patient has failed surgery or is not a surgery candidate
6/2014	Annual Review
12/2015	Updated reauthorization verbiage to state improved/stable glucose tolerance rather than glucose intolerance for clarity
10/2016	Removed prescriber requirement Removed 'not pregnant' from criteria.
12/2016	Updated formatting, background, and references.
3/2017	Changed authorization durations to 12 months. Updated references.
3/2018	Annual review. Updated references.
3/2019	Annual review with no changes.

3/2020	Annual review. Updated reference.