UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2023 P 1056-12
Program	Prior Authorization/Notification
Medication	Korlym® (mifepristone)
P&T Approval Date	4/2012, 4/2013, 4/2014, 4/2015, 2/2016, 12/2016, 3/2017, 3/2018, 3/2019, 3/2020, 3/2021, 3/2022, 3/2023
Effective Date	6/1/2023; Oxford only: 6/1/2023

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.[1]

2. Coverage Criteria[a]:

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 6 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 6 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4. References:

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

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Change Control	
4/2014	Annual review with update to background, reauthorization criteria and references.
4/2015	Annual review with update to reference.
2/2016	Annual review. Removed 'not pregnant' from criteria.
12/2016	Annual review. Updated formatting, background and references.
3/2017	Annual review with no changes to coverage criteria. Updated background and references.
3/2018	Annual review with no changes to coverage criteria. Updated references.
3/2019	Annual review with no changes.
3/2020	Annual review with no changes to coverage criteria. Updated references.
3/2021	Annual review with no changes to coverage criteria.
3/2022	Annual review. No changes.
3/2023	Annual review with no changes to coverage criteria. Added state mandate footnote.