UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

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| Program Number | 2024 P 1056-13 |
| 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, 3/2024 |
| Effective Date | 6/1/2024 |

**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 12 months.**

**B. Reauthorization**

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

a. Documentation of a positive clinical response while on Korlym therapy

**Authorization will be issued for 12 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. |
| 3/2024 | Annual review. Updated approval duration of coverage criteria to 12 months. Updated reauthorization criteria. |