UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

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| Program Number | 2026 P 1521-1 |
| Program | Prior Authorization/Notification |
| Medication | Lifyorli™ (relacorilant) |
| P&T Approval Date | 5/2026 |
| Effective Date | 8/1/2026 |

**1. Background:**

Lifyorli™ (relacorilant) is a glucocorticoid receptor antagonist indicated in combination with nab-paclitaxel for the treatment of adults with platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer who have received one to three prior systemic treatment regimens, at least one of which included bevacizumab.

**Coverage Information:**
Members will be required to meet the criteria below for coverage. For members under the age of 19 years, the prescription will automatically process without a coverage review.

Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances. Some states also mandate usage of other Compendium references. Where such mandates apply, they supersede language in the benefit document or in the notification criteria.

**2. Coverage Criteria[a]:**

**A. <u>Patients less than 19 years of age</u>**

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

   a. Patient is less than 19 years of age

   **Authorization will be issued for 12 months.**

**B. <u>Ovarian, Fallopian Tube, and Peritoneal Cancer</u>**

1. **<u>Initial Authorization</u>**

   a. **Lifyorli** will be approved based on **<u>all</u>** of the following criteria:

      (1) **<u>One</u>** of the following diagnoses:

         (a) Epithelial ovarian cancer
         (b) Fallopian tube cancer
         (c) Primary peritoneal cancer

      **-AND-**

      (2) Disease is platinum-resistant

**-AND-**

(3) Patient has received one prior bevacizumab-containing systemic treatment regimen

**-AND-**

(4) Patient has not received more than three prior systemic treatment regimens

**-AND-**

(5) Used in combination with nab-paclitaxel

**Authorization will be issued for 12 months.**

2. **Reauthorization**

a. **Lifyorli** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Lifyorli therapy

**Authorization will be issued for 12 months.**

**C. NCCN Recommended Regimens**

The drug has been recognized for treatment of the cancer indication by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B

**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.
- Supply limits may be in place.

**4. References:**

1. Lifyorli [package insert]. Redwood City, CA: Corcept Therapeutics Incorporated; March 2026.

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| **Change Control** | |
| 5/2026 | New program |