Prescriber Criteria Form Korlym 2025 PA Fax 778-A v1 010125.docx Korlym (mifepristone) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Korlym (mifepristone).

Drug Name: Korlym (mifepristone)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of endogenous Cushing's syndrome? [If no, then no further questions.]	Yes ◯	No ◯
2	Does the patient have type 2 diabetes mellitus or glucose intolerance? [If no, then no further questions.]	Yes ◯	No ◯
3	Is the requested drug being used to control hyperglycemia secondary to hypercortisolism? [If no, then no further questions.]	Yes ◯	No ◯
4	Is the patient a candidate for surgery? [If no, then skip to question 6.]	Yes ◯	No ◯
5	Has the patient had surgery that was not curative? [If no, then no further questions.]	Yes ◯	No ◯
6	Is the requested drug being prescribed by or in consultation with an endocrinologist?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____