AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: mifepristone 300 mg (Korlym®)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Quantity Limits: 120 tablets per 30 days

Recommended Dosage: Initiate therapy with 300 mg/day and titrate dose every 2-4 weeks based on tolerability and symptom control, and daily dose will NOT exceed 20 mg/kg/day, OR 1,200 mg once daily

CLINICAL CRITERIA: Check below all that apply. **All criteria must be met for approval.** To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ❑ Member is 18 years of age or older
- ❑ Prescribing physician is an endocrinologist

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- ❑ Member has a diagnosis of Endogenous Cushing's Syndrome, and satisfies **ONE** of the following:
  - ❑ Diagnosis of Type 2 Diabetes Mellitus
  - ❑ Glucose intolerance noted by **ONE** of the following **(must submit documentation)**: oral glucose tolerance test or Hemoglobin A1c test (HbA1c)
- ❑ Past medical history confirms **ONE** of the following:
  - ❑ Member has undergone surgery and has not been curative
  - ❑ Member is **NOT** a candidate for surgery
- ❑ Documentation of clinical failure (unable to normalize cortisol levels for the treatment of Cushing's Syndrome) to ketoconazole tablets taken along with **ONE** of the following:
  - ❑ An additional steroidogenesis inhibitor such as Metopirone® (metyrapone capsules) or mitotane tablets
  - ❑ A pituitary-directed therapy such as cabergoline or Signifor® LAR (pasireotide)
- ❑ Documentation of clinical failure to control glucose levels with metformin **AND TWO (2)** of the following treatments:
  - ❑ Glucagon-Like Peptide-1 (GLP-1) Receptor Agonist (e.g., Trulicity®, Ozempic®)
  - ❑ Insulin (e.g., Humalog®, Lantus®)
  - ❑ Dipeptidyl Peptidase 4 (DPP-4) Inhibitor (e.g., Januvia®, Onglyza®)
- ❑ Member is **NOT** also taking/ will **NOT** take strong inhibitors of CYP2A medications (e.g., simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, tacrolimus)
- ❑ For females of reproductive potential: pregnancy has been excluded before initiation of treatment and plans for prevention are implemented during treatment and for one month after stopping

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Positive disease response has been achieved, demonstrated by improved glycemic control (decreased hemoglobin A1c) **(current labs must be submitted to document HbA1c)**

Medication being provided by a Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*