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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Korlym[®] Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Hyperglycemia					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information:					
Does the patient have endogenous Cushing's syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have type 2 diabetes mellitus? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have glucose intolerance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have hyperglycemia that is secondary to hypercortisolism? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the patient a candidate for surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient failed surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is Korlym prescribed by or in consultation with an endocrinologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If female, is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Reauthorization:					
Does the patient have improved glucose tolerance while on Korlym therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have stable glucose tolerance while on Korlym therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Quantity Limit Requests:					
What is the quantity requested per DAY? _____					
What is the reason for exceeding the plan limitations?					
<input type="checkbox"/> Titration or loading dose purposes					
<input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)					
<input type="checkbox"/> Requested strength/dose is not commercially available					
<input type="checkbox"/> Other: _____					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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