

KORLYM

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis:

- Cushing’s Syndrome
- Other (Please include ICD code plus description): _____

Medication Requested:	Strength:
-----------------------	-----------

Dosing Schedule:	Quantity per Month:
------------------	---------------------

For all requests:

1. What is the patient’s weight? _____ (kg)
2. Is the patient currently treated with the requested agent? Yes No
If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.**..... Yes No
3. Does the patient have any FDA labeled contraindications to the requested agent?..... Yes No
If yes, please specify FDA labeled contraindications: _____
4. Is the patient’s age within FDA labeling for the requested indication for the requested agent? Yes No
If no, please provide support for using the requested agent for the patient’s age for the requested indication: _____
5. Does the patient have type 2 diabetes mellitus? Yes No
If no, does the patient have glucose intolerance as defined by a 2-hr glucose tolerance test plasma glucose value of 140-199 mg/dL? Yes No
6. Has the patient had an inadequate response to surgical resection?..... Yes No
If no, is the patient a candidate for surgical resection? Yes No
7. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., endocrinologist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? Yes No
8. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
For brand Korlym requests:			
<ul style="list-style-type: none"> Please submit chart notes to support the answers to the following questions: 			
9. Has the patient tried and had an inadequate response to the generic equivalent (mifepristone) that is NOT expected to occur with the brand agent? <input type="checkbox"/> Yes <input type="checkbox"/> No			
10. Is there support for the use of the requested brand agent Korlym, over the generic equivalent mifepristone? <input type="checkbox"/> Yes <input type="checkbox"/> No			
11. Was the generic equivalent (mifepristone) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
12. Does the patient have an intolerance or hypersensitivity to the generic equivalent (mifepristone) that is NOT expected to occur with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No			
13. Does the patient have an FDA labeled contraindication to the generic equivalent (mifepristone) that is NOT expected to occur with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No			
14. Is the generic equivalent (mifepristone) expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? <input type="checkbox"/> Yes <input type="checkbox"/> No			
15. Is the generic equivalent (mifepristone) NOT in the best interest of the patient based on medical necessity?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
16. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the generic equivalent (mifepristone) and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? <input type="checkbox"/> Yes <input type="checkbox"/> No			
For all renewal requests:			
17. Has the patient had clinical benefit with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121 TOLL FREE		CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.	
Phone: BCBSIL: 800.285.9426 BCBSMT: 888.723.7443 BCBSNM: 800.544.1378 BCBSOK: 800.991.5643 BCBSTX: 800.289.1525		Fax: 877.243.6930	