Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Korlym
(mifepristone)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: (*please specify name, strength, and dosing schedule)*
☐ Korlym 300mg ICD10: Patient's current weight: lb. or kg:

Directions for use: Quantity: Duration of therapy:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of Korlym, please choose new start of therapy. ☐ new start ☐ continued therapy
(if continued therapy) Has your patient had a documented response to therapy (such as an improvement in fasting glucose, oral glucose tolerance, or hemoglobin A1c results)? ☐ Yes ☐ No
(if no) Please provide clinical support for the continued use of Korlym: _____

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:

****This drug requires supportive documentation (i.e. chart notes, etc). Supportive documentation for all answers must be attached with this request.*****

Does your patient have a diagnosis of endogenous Cushing's syndrome? ☐ Yes ☐ No
(if no) What is the diagnosis related to use? _____

(if Cushing's syndrome) Does your patient have Type 2 diabetes mellitus or impaired glucose tolerance? ☐ Yes ☐ No
(if Cushing's syndrome) Which of the following applies to your patient?
- ☐ Patient previously had surgery that failed
- ☐ Surgery is not an option
- ☐ none of the above

Additional Pertinent Information: (*please include clinical support for the use of this drug in your patient, relavent lab values, etc)*:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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