Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

# Horizon NJ Health

## *Korlym® (mifepristone) – Medical Necessity Request*

***Complete page 1 for Initial Requests Only****

1. Does the member have a diagnosis of Cushing's syndrome?
   - □ **No** – What is the diagnosis? _____
   - □ **Yes**
     a. Does the member also have Type 2 diabetes mellitus? **Yes or No**
     b. Does the member have glucose intolerance? **Yes or No**
     c. Has the member failed surgical resection? **Yes or No**
     d. Is the member a candidate for surgery? **Yes or No**

2. Is Korlym being prescribed by or in consultation with an Endocrinologist? **Yes or No**

3. Does the member have any of the following contraindications to therapy?
   - □ Pregnancy
   - □ Taking drugs metabolized by CYP3A such as simvastatin, lovastatin, and CYP3A substrates with narrow therapeutic ranges, such as cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, and tacrolimus
   - □ Receiving systemic corticosteroids for lifesaving purposes (e.g., immunosuppression after organ transplantation)
   - □ History of unexplained vaginal bleeding or with endometrial hyperplasia with atypia or endometrial carcinoma
   - □ None of the above

4. What is the member's current weight? _____lbs or _____kg

**Physician office's signature*_____ Print Name_____**
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

## Horizon NJ Health

### *Korlym® (mifepristone) – Medical Necessity Request*

***Complete page 2 only for Subsequent/Renewal requests****

1. Has the member shown improvement or stabilization of glucose control in fasting serum glucose test, oral glucose tolerance test or hemoglobin A1c test? **Yes or No**

2. What is the member's current weight? _____lbs or _____kg

**Physician office's signature*_____ Print Name_____**

***Form must be completed and signed by physician or licensed representative from the physician's office**