UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1056-15
Program	Prior Authorization/Notification
Medication	Korlym® (mifepristone)
P&T Approval Date	4/2012, 4/2013, 4/2014, 4/2015, 2/2016, 12/2016, 3/2017, 3/2018, 3/2019, 3/2020, 3/2021, 3/2022, 3/2023, 3/2024, 3/2025, 3/2026
Effective Date	6/1/2026

1. Background:

Korlym (mifepristone) is a cortisol receptor blocker indicated to control hyperglycemia secondary to hypercortisolism in adult patients with endogenous Cushing's syndrome who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery.

Korlym is not indicated for the treatment of type 2 diabetes mellitus unrelated to endogenous Cushing's syndrome.

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Korlym** will be approved based on **all** of the following criteria:

   a. Diagnosis of endogenous Cushing's syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids)

   -AND-

   b. **One** of the following:

      (1) Diagnosis of type 2 diabetes mellitus

      (2) Diagnosis of glucose intolerance

   -AND-

   c. **One** of the following:

      (1) Patient has failed surgery

      (2) Patient is not a candidate for surgery

   Authorization will be issued for 12 months.

B. Reauthorization

1. **Korlym** will be approved based on the following criterion:

    a. Documentation of a positive clinical response while on Korlym therapy

    Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4. References:

1. Korlym [Package Insert]. Redwood City, CA: Corcept Therapeutics, Inc.; September 2024.

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Change Control	
4/2014	Annual review with update to background, reauthorization criteria and references.
4/2015	Annual review with update to reference.
2/2016	Annual review. Removed 'not pregnant' from criteria.
12/2016	Annual review. Updated formatting, background and references.
3/2017	Annual review with no changes to coverage criteria. Updated background and references.
3/2018	Annual review with no changes to coverage criteria. Updated references.
3/2019	Annual review with no changes.
3/2020	Annual review with no changes to coverage criteria. Updated references.
3/2021	Annual review with no changes to coverage criteria.
3/2022	Annual review. No changes.
3/2023	Annual review with no changes to coverage criteria. Added state mandate footnote.
3/2024	Annual review. Updated approval duration of coverage criteria to 12 months. Updated reauthorization criteria.
3/2025	Annual review with no changes to coverage criteria. Updated reference.
3/2026	Annual review with no changes to coverage criteria.