

## CARE VALUE POLICY

**POLICY:** Cushing's – Mifepristone Care Value Policy

- Korlym<sup>®</sup> (mifepristone tablets – Corcept, generic)

**REVIEW DATE:** 4/24/2024; effective 07/15/2024

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### OVERVIEW

Mifepristone, a cortisol receptor blocker, is indicated to control hyperglycemia secondary to hypercortisolism in adults with **endogenous Cushing's syndrome** who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery.<sup>1</sup>

Mifepristone should not be used for the treatment of type 2 diabetes mellitus unrelated to endogenous Cushing's syndrome.<sup>1</sup>

### POLICY STATEMENT

This Care Value program has been developed to encourage the use of the Preferred Product. For the Non-Preferred Product only, the patient is required to meet the respective standard *Cushing's – Mifepristone Prior Authorization Policy* criteria. Requests for the Preferred Product does not have to meet standard Prior Authorization Policy criteria. Requests for Non-Preferred Product will also be reviewed using the exception criteria (below). All approvals are provided for 1 year in duration.

**Documentation:** Documentation will be required where noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and/or other information.

**Automation:** None.

**Preferred Product:** Generic mifepristone tablets  
**Non-Preferred Product:** Korlym

**RECOMMENDED EXCEPTION CRITERIA**

| <b>Non-Preferred Product</b> | <b>Exception Criteria</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Korlym                       | <p>1. Patient meets BOTH of the following (A <u>and</u> B):</p> <p><b>A)</b> Patient meets the standard <i>Cushing's – Mifepristone Prior Authorization Policy</i> criteria; AND</p> <p><b>B)</b> Patient meets BOTH of the following (i <u>and</u> ii):</p> <p><b>i.</b> Patient has tried generic mifepristone tablets; AND</p> <p><b>ii.</b> Patient cannot continue to use generic mifepristone tablets due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] which, per the prescriber, would result in a significant allergy or serious adverse reaction <b>[documentation required]</b>.</p> |

**REFERENCES**

1. Korlym® tablets [prescribing information]. Menlo Park, CA: Corcept; March 2020.

**History**

| <b>Type of Revision</b> | <b>Summary of Changes</b> | <b>Review Date</b> |
|-------------------------|---------------------------|--------------------|
| New Policy              | Effective 07/15/2024.     | 04/24/2024         |