

Patient Enrollment and Prescription Form for Korlym® (mifepristone)

SPARK 

Support Program for Access and Reimbursement for Korlym

FAX: 1-855-288-0601



SPARK Phone: 1-855-4KORLYM (1-855-456-7596)

Patient Information

Name:	Date of Birth (DOB) (MM/DD/YYYY):	☐ Male	☐ Female
Address:	APT #:	City/State/Zip:	
Email:	Preferred Language:	☐ English ☐ Spanish ☐ Other:	
Cell Phone:	Alternate Phone:		
Best Time to Contact:	Additional Detail:		
☐ Morning ☐ Afternoon ☐ Evening			
Alternate Contact Name and Cell Phone:			

Insurance Information

Please include front and back copies of all medical and pharmacy cards and complete this section.

☐ Commercial/Private insurance ☐ No insurance

☐ Medicare/Medicaid/Tricare

Primary Prescription Insurance	Secondary Prescription Insurance	Pharmacy Insurance
Insurance Provider		
Insurance Phone #		
Cardholder Name (if not the patient)		
Cardholder DOB (MM/DD/YYYY)		
Policy #		
Group #		
BIN/PCN		

Medical Necessity

Primary Diagnosis: Cushing syndrome—please select the source:

☐ E24.0 (Pituitary) ☐ E24.8 (Adrenal) ☐ C74.0 (Adrenal carcinoma)

☐ E24.3 (Ectopic ACTH) ☐ E24.9 (Unknown source)

Secondary Diagnosis: Type 2 diabetes mellitus (DM) with hyperglycemia: ☐ E11.65

DM due to underlying condition: ☐ E08.8 (with unspecified complications) ☐ E08.9 (without complications)

Abnormal glucose: ☐ R73.01 ☐ R73.02 ☐ R73.03 ☐ R73.09 ☐ R73.9 Long-term use of insulin: ☐ Z79.4 Insulin resistance: ☐ E88.81

☐ Other ICD-10 Code (related to DM/glucose intolerance): _____

☐ **Prior or current Cushing therapy:** _____

Explanation why the patient is not a candidate for surgery: ☐ Prior surgery was unsuccessful ☐ Source unknown and/or tumor could not be located

☐ Patient refused surgery ☐ Patient is a high-risk surgical candidate ☐ Poor surgical wound healing potential ☐ Patient has bilateral adrenal disease

☐ Other: _____ [Please include chart notes related to this section along with this enrollment form]

Prescription Information Select 1 dosing instruction & # of refills

Korlym® (mifepristone) 300 mg Tablets

Dosage Guidance (for reference only, prescriber may individualize):
Initiate dosing at **300 mg** once daily. Titrate based on tolerability and response.
Maximum daily dose is the lower of 1200 mg or 20 mg/kg/day.
Maximum dose of 600 mg/day in renal/hepatic impairment and not for use in severe hepatic impairment.

☐ Take 1 (one) tablet (300 mg) by mouth daily for 14 days , then increase to 2 (two) tablets (600 mg) daily for 16 days . Refill prescription: Take 2 (two) tablets (600 mg) by mouth daily.	[Initial prescription QTY 46] [Refill QTY 60]	Number of 60 tablet refills: _____
☐ Take 1 (one) tablet (300 mg) by mouth daily for 30 days . Refill prescription: Take 2 (two) tablets (600 mg) by mouth daily.	[Initial prescription QTY 30] [Refill QTY 60]	Number of 60 tablet refills: _____
☐ Take 1 (one) tablet (300 mg) by mouth daily for 30 days .	[QTY 30]	Number of 30 tablet refills: _____
☐ Custom dosing instructions: _____	[QTY: _____]	Number of refills: _____

To discuss other dosing options (600 mg, 900 mg, or 1200 mg), call the specialty pharmacy. Korlym tablets should not be split, crushed, or chewed.

Prescriber Certification, Information, & Instruction for Pharmacy

By signing below, I certify that the above therapy is medically necessary and that I will supervise the patient's treatment accordingly; I appoint Corcept and its agents to convey this prescription to the dispensing pharmacy.

Prescriber Name:	Specialty:
Prescriber NPI #:	Prescriber DEA #:
Email:	
Address:	City/State/Zip:
Phone:	Fax:

Dispense as written (Prescriber's signature)	Date	Substitution allowed (Prescriber's signature)	Date
		OR 	

Prescriber's full, usual, and actual signature is required—no stamps. This form cannot be processed without the prescriber's signature.

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Most payers require a prior authorization (PA) before they will approve a prescription for Korlym. SPARK (Support Program for Access and Reimbursement for Korlym) is a program that can help you prepare the PA. If the payer allows, SPARK can submit the PA on behalf of you and the patient. In some cases, the payer requires the physician to submit the PA. In those cases, SPARK can prepare the PA paperwork and send it to your office so that you can send it to the payer. SPARK will inform you of the process for each patient.

If you would like SPARK's assistance preparing the prior authorization, please FAX the following clinical documentation requested below with all 3 pages of this SPARK enrollment form.

Patient Name: _____ DOB: _____

(MM/DD/YYYY)

Check the boxes below to indicate what you are faxing.

- ☐ Copy of **insurance card** (both sides)
- ☐ Copy of **Rx benefit card** (both sides)
- ☐ **Relevant lab report for test(s) performed to diagnose endogenous Cushing syndrome**

Examples (required for diagnosis):

DST (dexamethasone suppression test)

LNSC (late-night salivary cortisol) test

UFC (urine free cortisol) test

Examples (optional for diagnosis):

ACTH (adrenocorticotrophic hormone)

DHEA-Sulfate (dehydroepiandrosterone sulfate) test

Radiology report/Imaging

- ☐ **Relevant lab report for HbA1c or other glucose test(s) performed** to diagnose type 2 diabetes or glucose intolerance within last 6 months (ideally). Within last year is acceptable.

Examples:

HbA1c

Fasting glucose

OGTT (oral glucose tolerance test)

Fasting insulin

- ☐ Chart notes supporting the following:
 - ☐ Diagnosis of **endogenous hypercortisolism or Cushing syndrome**
 - ☐ Diagnosis of **hyperglycemia and any other comorbidities**
 - ☐ **Prior surgical details or notes on lack of surgical candidacy**

- ☐ List of **current medications**
- ☐ List of **previous medications prescribed to treat Cushing syndrome** (and explanation of discontinuation, if noted)
- ☐ Confirmation of **negative pregnancy test** in female patients of reproductive potential

Contact name from prescriber's office and best contact information

For medical questions (RN/MA): _____

Phone/Email: _____

Prior authorization questions: _____

Phone/Email: _____

Corcept Cares Patient Support Authorization for Korlym® (mifepristone)

Fax completed form to: **1-855-288-0601**

Once your prescription is received by SPARK, a **SPARK Patient Access Coordinator** will reach out to you to assist with insurance coverage, financial aid options, and to schedule your medication shipments. You will also gain access to one-on-one support from a dedicated Corcept Cares Patient Advocate. They are specially trained in your condition and Corcept medication(s). They can provide information, resources, and support on: your condition, what to expect during treatment including the importance of monitoring, and how your medication works.

Patient Authorization to Share Protected Health Information (to be completed by patient)

For a Corcept Cares Patient Advocate to contact you, please sign the HIPAA authorization below

By signing below, I give permission for all of my healthcare providers, pharmacies, service providers, health plans, and health insurer(s) including their vendors to use and disclose any and all necessary information including, but not limited to, my medical prescriptions, medical diagnosis, condition, treatment, financial documents, prescription coverage, health records and identifying information including, but not limited to, name, date of birth, address, email address, and telephone number (collectively, "Protected Health Information" or "PHI") to Corcept Therapeutics Incorporated and all of its affiliates, service providers, and agents (collectively, "Corcept"). My PHI will be shared with Corcept for the purpose of providing me with support and information to help me access Korlym, its authorized generic, or other Corcept medicines, which may include the following: (1) Providing benefits investigations and/or verification reimbursement support including identification of my health plan or insurer's prior authorization requirements, identification of my insurer's requirements for appealing a denied claim, determining my eligibility for and helping me access financial assistance resources if I am eligible; (2) Coordinating the dispensing and delivery of a Corcept medicine, including authorization for Corcept to determine and select the pharmacy to which my prescription will be directed; (3) Providing me with disease management and other educational materials as well as information about Corcept's products and services, which may include sending me surveys about my experience with Corcept's products and services; (4) Providing me with emotional support as well as information and resources on my condition through the Corcept Cares Patient Advocate Program; and (5) Conducting internal quality and business analysis to evaluate and improve Corcept's operations and services. Failure to sign the HIPAA authorization will not affect my medical care or access to Korlym or other Corcept medication.

I understand and acknowledge that while Corcept will make good faith efforts to keep PHI private, once PHI is disclosed to third parties it may no longer be protected by federal and state privacy and security laws and may be subject to redisclosure. I understand that I may also revoke (withdraw) this authorization at any time by contacting Corcept at consent@korlymhub.com. Such revocation will not affect my ability to get treatment from my healthcare providers or to seek payment or benefits from a health plan or insurer. However, if I revoke this authorization, I can no longer participate in the programs and/or services administered by Corcept, such as the Corcept Cares Patient Advocate Program. If I revoke this authorization, Corcept will stop using or disclosing my PHI except as necessary to end participation, but such revocation will not affect uses and disclosures of PHI made in reliance upon this authorization. I understand that this authorization will expire one (1) year after discontinuation of my treatment with Corcept medicines, or if applicable state law requires a shorter duration, such duration shall govern the expiration of this authorization. I understand that I am entitled to receive a copy of this authorization.

- ☐ (Optional) By checking this box, I agree to receive text messages from Corcept or parties acting on Corcept's behalf to facilitate my participation in SPARK and to provide me with additional resources and information as a part of the Corcept Cares Patient Advocate Program. I understand that I can opt out of these communications at any time by contacting Corcept at 1-855-212-CORT. I understand that my consent is not required and is not a condition of purchasing goods or receiving services from Corcept. Standard message and data rates may apply. I understand that I can review the Corcept Privacy Notice at <https://corcept.com/privacy-notice/>.
- ☐ (Optional) By checking this box, I consent to my pharmacy leaving detailed messages via voicemail regarding my prescription.

By signing below, I acknowledge that I have read, understood, and agree to the Patient Authorization to Share Protected Health Information above.



Patient/Legal Representative Signature

If signed by someone other than the patient, describe your authority to sign on behalf of the patient.

Print Patient Name

Today's Date

Consent will be deemed invalid without today's date.

Prescriber Name: _____

Patient's Date of Birth (DOB): _____
(MM/DD/YYYY)