SPARK

Support Program for Access and Reimbursement for Korlym®

Korlym®
mifepristone
300 mg Tablets

SPARK Contact Center

1-855-4Korlym (1-855-456-7596)

Fax 1-877-858-7746

Complete and Fax These Forms

- ☐ **Page 1** – Patient Information, Insurance, Medical Information and Statement of Medical Necessity
- ☐ **Page 3** – Prescription Information, Physician Certification

Provide Copies of These Documents Along With Completed Forms

- ☐ Both sides of insurance card
- ☐ Prescription benefit card (if applicable)
- ☐ Lab test results, imaging results, and chart notes confirming the diagnosis of Cushing syndrome (eg, UFC, DST, ACTH, LNSC, radiology reports)
- ☐ Lab test results and chart notes demonstrating type 2 diabetes or glucose intolerance (eg, HbA1c, OGTT, fasting glucose)
- ☐ Prior surgical notes/surgeon consult notes (if applicable)
- ☐ Negative pregnancy test for women of reproductive potential

Fax Your Completed Forms and Documents

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NY prescribers — Please submit prescription on an original NY State prescription blank.

Corcept THERAPEUTICS

SPARK Support Program for Access and Reimbursement for Korlym®

Patient Enrollment Form for Korlym

Effective May 2021

SPARK Contact Center
1-855-4Korlym (1-855-456-7596)
Fax 1-877-858-7746

1 Patient Information

Name: _____

Date of Birth: ___ / ___ / _____ (MM / DD / YYYY) Sex: ◯ M ◯ F

Address: _____

City: _____ State: ___ ZIP: _____

Email: _____

Preferred Phone: ___–___–_____ ◯ Mobile ◯ Home

Alternate Phone: ___–___–_____ ◯ Mobile ◯ Home

Best Time to Contact: _____

Patient Authorization

I have read and agree to the Patient Certifications and Patient Authorization to Use and Disclose Health Information on page 2.

> _____ ___ / ___ / _____
> Patient/Legal Representative Signature MM DD YYYY
> Today's Date

Relationship to Patient (If signed by someone other than the patient, such as a parent or legal guardian, please describe your authority to sign on behalf of the patient.)

_____

2 Insurance

Primary Insurance

Please attach a copy of both sides of the patient's insurance card(s).

Primary Insurance Carrier: _____

Insurance Phone: ___–___–_____

Policy ID #: _____ Group #: _____

Policy Holder Name: _____

Policy Holder Date of Birth: ___ / ___ / _____ (MM / DD / YYYY)

Relationship to Patient: _____

Employer Name: _____

Pharmacy Benefits - Prescription Drug Card

Please provide a copy of patient's prescription benefit card.

Rx Insurance Carrier (if different): _____

Rx Insurance Phone: ___–___–_____

Subscriber Name: _____

Rx Bin #: _____

Policy ID #: _____ Group #: _____

Policy Holder Name: _____

Policy Holder Date of Birth: ___ / ___ / _____ (MM / DD / YYYY)

3 Medical Information and Statement of Medical Necessity

Please fill out completely (see page 2 of form or cover page for checklist of information and items to be faxed in with this enrollment form).

Primary Diagnosis

Please check the type of Cushing syndrome, if known.

ACTH-dependent

- ☐ Pituitary – E24.0
- ☐ Ectopic – E24.3

ACTH-independent

- ☐ Adrenal – E24.8
- ☐ Adrenal carcinoma – C74.0

☐ **Unknown** – E24.9

▸ **If the patient is female and of reproductive potential, has a negative pregnancy test been confirmed?** ◯ Yes ◯ No

▸ **Does the patient have diabetes, prediabetes, or glucose intolerance?** ◯ Yes ◯ No
if yes, please provide ICD-10 code/s: _____

▸ **Is the patient a candidate for surgery related to Cushing syndrome?** ◯ Yes ◯ No

▸ **Please list any surgical procedures related to Cushing syndrome that the patient has undergone, including related chart notes, prior surgery notes, or surgeon consults (if applicable):**

▸ **Surgery may not be an option for some patients with Cushing syndrome. Please provide written rationale for such patients, as ICD-10 codes do not cover these circumstances:**

▸ **Please list any prescription medications related to Cushing syndrome that the patient has received, or explain why the patient is unable to take another medication for Cushing syndrome (provide documentation, if applicable):**

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Important Documentation to be Sent in With Enrollment Form

Please provide the relevant documentation listed below in addition to pages 1 and 3.

- ☐ Lab test results, imaging results, and chart notes confirming the diagnosis of Cushing syndrome (eg, UFC, DST, ACTH, LNSC, radiology reports)
- ☐ Lab test results and chart notes demonstrating type 2 diabetes or glucose intolerance (eg, HbA1c, OGTT, fasting glucose)
- ☐ Prior surgical notes/surgeon consult notes (if applicable)
- ☐ Negative pregnancy test for women of reproductive potential

ACTH=adrenocorticotropic hormone; DST=dexamethasone suppression test; HbA1c=hemoglobin A1c; LNSC=late-night salivary cortisol; OGTT=oral glucose tolerance test; UFC=urinary-free cortisol.

Prior Authorization Information

Most payers require a prior authorization before they will approve a prescription for Korlym® (mifepristone). SPARK (Support Program for Access and Reimbursement for Korlym) is a program that can help you prepare the payer prior authorization. If the payer allows, SPARK can submit the prior authorization on behalf of you and the patient. In some cases, the payer requires the physician to submit the prior authorization. In those cases, SPARK can prepare the prior authorization 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 this completed form and appropriate clinical documentation, along with the prescription enrollment form, to 1-877-858-7746.

Patient Consent and HIPAA Authorization

I hereby authorize my healthcare providers and my health insurance carriers to disclose my personally identifiable health information, including my medical diagnosis, condition, and treatment (including prescription information), my health insurance, and my name, email, address, and telephone number to Corcept Therapeutics Incorporated (Corcept), their agents, and representatives, including third parties authorized by Corcept to administer SPARK and to dispense Korlym, for the following purposes: 1) to contact my healthcare providers to collect, enter, and maintain my health information in a database and to provide information related to my treatment; 2) to contact my insurers as needed to verify my insurance coverage, review reimbursement issues, and assist with the processing of claims; 3) to administer SPARK and to dispense Korlym; 4) to contact me to receive educational and therapy support services designed for people taking Korlym.

I understand that federal privacy laws may no longer protect my health information after its disclosure to Corcept and that it may be subject to redisclosure. Corcept agrees to protect my health information by using and disclosing my information only for the reasons listed above.

I understand that I may revoke (withdraw) this authorization at any time by faxing a signed, written request to the SPARK Contact Center at 1-877-858-7746. The Contact Center will notify my healthcare provider and insurers of my revocation, who may therefore no longer disclose my health information to Corcept once they have received and processed that notice. However, revoking this authorization will not affect Corcept's ability to use and disclose my health information that has already been received to the extent permitted under applicable law. If I revoke this authorization, I will no longer be able to receive SPARK Contact Center services.

However, the revocation of this authorization will not affect my ability to get treatment from my healthcare providers or to seek payment or eligibility for benefits from a health plan.

This authorization will not expire unless I revoke it.

For more information on Corcept's privacy practices, visit corcept.com/privacy.

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4 Prescription Information

Patient Name: _____

Patient Date of Birth: ___ / ___ / _____
MM DD YYYY

Korlym® (mifepristone) 300 mg Tablets

Initial dosage: 300 mg once daily **Dosage and administration:** Based on clinical response and tolerability, the dose may be increased in 300 mg increments to a maximum of 1200 mg once daily. Do not exceed 20 mg/kg/day.

Please check one of the dosing instructions below and indicate the number of refills, or write in customized dosing instructions for your patient.

Initial titration dosing option

Refills

◯ Sig: Take 1 (one) tablet (300 mg) by mouth daily for 14 days, then increase to 2 (two) tablets (600 mg) daily. QTY 46

Number of 60 Tablet Refills: _____

Sig: Take 2 (two) tablets (600 mg) by mouth daily. QTY 60

Other dosing options

Refills

◯ Sig: Take 1 (one) tablet (300 mg) by mouth daily. QTY 30 — Number of 30 Tablet Refills: _____

◯ Sig: Take 2 (two) tablets (600 mg) by mouth daily. QTY 60 — Number of 60 Tablet Refills: _____

◯ Sig: Take 3 (three) tablets (900 mg) by mouth daily. QTY 90 — Number of 90 Tablet Refills: _____

◯ Sig: Take 4 (four) tablets (1200 mg) by mouth daily. QTY 120 — Number of 120 Tablet Refills: _____

Customized dosing directions

Take: _____ QTY: _____ Number of Refills: _____

5 Physician Certification

By signing below, I certify that (a) the above therapy is medically necessary and that I will supervise the patient's treatment accordingly; (b) I have received the necessary authorizations, including those required by state law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to release the above information and other health and medical information of the patient to Corcept Therapeutics Incorporated (Corcept), its agents, and contracted dispensing pharmacies, to assist the patient in obtaining coverage for Korlym. I appoint Corcept and its agents to convey this prescription to the dispensing pharmacy.

Prescriber's Information:

Prescriber Name: _____

Prescriber NPI #: _____

Specialty: _____

Address: _____

City: _____ State: ___ ZIP: _____

Phone: ___–___–_____ Fax: ___–___–_____

Email: _____

Prescriber instructions for pharmacy (Select one):

◯ DISPENSE AS WRITTEN

Prescriber's Signature: _____ ___ / ___ / _____
MM DD YYYY

◯ SUBSTITUTION ALLOWED

Prescriber's Signature: _____ ___ / ___ / _____
MM DD YYYY

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

Alternate Clinical Employee (RN/MA) Contact

Name: _____ Phone: ___–___–_____

Physician office staff member who handles Prior Authorizations

Name: _____ Phone/Email: _____

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ICD-10 Codes

Below are ICD-10 codes related to the diagnosis of Cushing syndrome and common comorbidities relating to diabetes and glucose intolerance. This reference may be useful when submitting prescriptions, filling out prior authorization forms, or filing insurance appeals for patients. It is the prescriber's responsibility to ensure that the correct code is being used.

Cushing Syndrome/ Hypercortisolism	Pituitary-dependent Cushing syndrome	E24.0
	Ectopic ACTH syndrome	E24.3
	Other Cushing syndrome (adrenal source)	E24.8
	Cushing syndrome (unspecified source)	E24.9
	Adrenal carcinoma	C74.0
Diabetes Mellitus/ Glucose Intolerance	Diabetes mellitus due to underlying condition with complications	E08.8
	Diabetes mellitus due to underlying condition without complications	E08.9
	Any use of insulin	Z79.4
	Impaired fasting glucose (elevated glucose)	R73.01
	Impaired glucose tolerance test (oral)	R73.02
	Other abnormal glucose (including latent and prediabetes)	R73.09
	Hyperglycemia unspecified	R73.9
	Insulin resistance/Hyperinsulinemia	E16.1

Surgery may not be an option for some patients with Cushing syndrome. **Written rationale should be provided for such patients, as ICD-10 codes do not cover these circumstances, which may include:**

- Prior surgery occurred and was unsuccessful
- Tumor could not be located using standard imaging studies
- Source of Cushing syndrome is unknown
- Patient has bilateral disease or one remaining adrenal gland
- Patient age and/or significant comorbidities create a higher surgical risk
- Increased risk due to comorbidities of Cushing syndrome (body mass index, obesity, glucose intolerance, hypertension, etc.)
- Patients with Cushing syndrome are at higher risk for deep vein thrombosis and infection following surgery
- Surgery may not be curative
- Poor surgical wound healing potential