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 (e.g., UFC, DST, ACTH, LNSC, radiology reports)
- Lab test results and chart notes demonstrating type 2 diabetes or glucose intolerance (e.g., 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

SPARK Contact Center
1-855-4Korlym (1-855-456-7596)
Fax 1-877-858-7746
SPARK Support Program for Access and Reimbursement for Korlym®

Patient Enrollment Form for Korlym
Effective September 2018

Page 1

1 Patient Information

Name:
Date of Birth: ___ / ___ / ______  Sex: ☐ M ☐ F
Address: ____________________________________________________________
City: _____________________________ State: _____ ZIP: __________
Email: ____________________________
Preferred Phone: ___ – ___ – ______  ☐ Mobile ☐ Home
Alternate Phone: ___ – ___ – ______  ☐ Mobile ☐ Home
Best Time to Contact: _______________________________________________

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: ___ / ___ / ______
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: ___ / ___ / ______

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  ☐ ACTH-independent  ☐ Unknown – €24.9
☐ Pituitary – €24.0  ☐ Adrenal – €24.8
☐ Ectopic – €24.3  ☐ Adrenal carcinoma – €74.0

» 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

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: __________________________
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.)  __________________________

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

Korlym® (mifepristone) 300 mg Tablets

Dosage and administration:
Initial dosage:
Dispense as Written

Customized dosing directions
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:

Follow-up visit:

Eff Ex 28 days

Refills

Then increase to 2 (two) tablets (600 mg) daily. QTY 46

Can be titrated to higher doses if appropriate, based on response to therapy.

Specialty:
Prescriber Name: __________________________
Prescriber NPI #: __________________________
Rx Insurance Phone: ___ – ___ – __________
Rx Insurance Carrier: __________________________
Rx Bin #: __________________________
Policy ID #: __________________________ Group #: __________
Policy Holder Name: __________________________
Policy Holder Date of Birth: ___ / ___ / ______
ICD-10 Codes

• Patient has bilateral disease or one remaining
• Source of Cushing syndrome is unknown
• Tumor could not be located using standard
• Prior surgery occurred and was unsuccessful

be provided for such patients, as ICD-10 codes do not cover these circumstances, which may include:

Written rationale should

Surgery may not be an option for some patients with Cushing syndrome.

that the correct code is being used.

prior authorization forms, or filing insurance appeals for patients. It is the prescriber's responsibility to ensure

to diabetes and glucose intolerance. This reference may be useful when submitting prescriptions, filling out

Below are ICD-10 codes related to the diagnosis of Cushing syndrome and common comorbidities relating

Diabetes Mellitus/

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

Poor surgical wound healing potential

Surgery may not be curative

Increased risk due to comorbidities of Cushing syndrome (body mass index, obesity, glucose
tolerance, hypertension, etc.)

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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, 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.
Prescription Information

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
  Number of 60 Tablet Refills: _________

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: _________

NY prescribers – Please submit prescription on an original NY State prescription blank.
MD prescribers – Check one of the following boxes and sign on the line next to it.

- Dispense as Written
- Substitution Allowed

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 Name: ____________________________

Specialty: ____________________________

Address: ____________________________

City: ____________________________ State: ______ ZIP: ______

Phone: _______ Fax: _______

Email: ____________________________

Alternate Clinical Employee (RN/MA) Contact

Name: ____________________________ Phone: _______

Physician office staff member who handles Prior Authorizations

Name: ____________________________ Phone/Email: ____________________________
**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.

<table>
<thead>
<tr>
<th>Cushing Syndrome/ Hypercortisolism</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pituitary-dependent Cushing syndrome</td>
<td>E24.0</td>
</tr>
<tr>
<td>Ectopic ACTH syndrome</td>
<td>E24.3</td>
</tr>
<tr>
<td>Other Cushing syndrome (adrenal source)</td>
<td>E24.8</td>
</tr>
<tr>
<td>Cushing syndrome (unspecified source)</td>
<td>E24.9</td>
</tr>
<tr>
<td>Adrenal carcinoma</td>
<td>C74.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diabetes Mellitus/ Glucose Intolerance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes mellitus due to underlying condition with complications</td>
<td>E08.8</td>
</tr>
<tr>
<td>Diabetes mellitus due to underlying condition without complications</td>
<td>E08.9</td>
</tr>
<tr>
<td>Any use of insulin</td>
<td>Z79.4</td>
</tr>
<tr>
<td>Impaired fasting glucose (elevated glucose)</td>
<td>R73.01</td>
</tr>
<tr>
<td>Impaired glucose tolerance test (oral)</td>
<td>R73.02</td>
</tr>
<tr>
<td>Other abnormal glucose (including latent and prediabetes)</td>
<td>R73.09</td>
</tr>
<tr>
<td>Hyperglycemia unspecified</td>
<td>R73.9</td>
</tr>
<tr>
<td>Insulin resistance/Hyperinsulinemia</td>
<td>E16.1</td>
</tr>
</tbody>
</table>

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