Patient Enrollment Form for Korlym®

Corcept THERAPEUTICS

SPARK Specialty Pharmacy
FAX: 1-877-858-7746

Korlym® mifepristone 300 mg Tablets

SPARK (Support Program for Access and Reimbursement for Korlym®) — SPARK Specialty Pharmacy Phone: 1-855-4KORLYM (1-855-456-7596)

Patient Information

Name		Date of Birth (DOB)	☐ Male ☐ Female
Address	City/State/Zip		
Email		Preferred Language: ☐ English ☐ Spanish Other:	
Cell Phone		Alternate Phone	
Best Time to Contact			
Alternate Contact Name and Cell Phone			

Insurance Information

Primary Insurance Carrier Name:		Insurance Phone	
Policy ID #		Group #	
Policy Holder Name		Relationship to Patient	
Policy Holder Employer Name		Policy Holder DOB	
Rx Insurance Carrier Name (if different):		Rx Phone	
Rx BIN #	Rx Policy ID #	Rx Group #	
Rx Policy Holder Name		Rx Policy Holder DOB	

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 DM with hyperglycemia: ☐ E11.65 Diabetes mellitus (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: ☐ E 16.1

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

Explanation Why 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

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.

○ 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 **14 days**, then increase to 2 (two) tablets (**600 mg**) daily. 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**.	[QTY 30]	Number of 30 tablet refills_____
○ Custom dosing directions: _____	[QTY _____]	Number of refills_____

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

Prescriber Certification, Information, & Instruction for Pharmacy

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 information submitted with this enrollment form 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
Prescriber NPI #	Email
Address	City/State/Zip
Phone	FAX

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

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

NY Prescribers–Please submit prescription on an original NY State prescription blank.

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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: _____

Check the boxes below to indicate what you are faxing.

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

  Examples:

  DST (Dexamethasone Suppression Test)
  LNSC (Late-Night Salivary Cortisol) test
  UFC (Urine-Free Cortisol) test
  ACTH (Adrenocorticotropic Hormone)
  DHEA-Sulfate (Dehydroepiandrosterone-Sulfate) test
  Radiology report/Imaging

- ☐ **Lab report for HbA1c or other glucose test(s) performed** to diagnose type 2 diabetes or glucose intolerance

  Examples:

  Fasting glucose
  Fasting insulin
  HbA1c
  OGTT (Oral Glucose Tolerance Test)

- ☐ **Chart notes on prior surgical details** or notes on prior surgeon consult or reasons why not a surgical candidate (if applicable)
- ☐ 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

CORCEPT CARES
where medicine meets compassion

FAX completed form to:
1-877-858-7746

Korlym® mifepristone 300 mg Tablets

Once your prescription is received by the SPARK Specialty Pharmacy, a **SPARK Care Coordinator** will reach out to you to assist with insurance coverage, financial aid options, and schedule your medication shipments. You will also have access to a **SPARK Pharmacist** who is exclusively dedicated to supporting patients prescribed Corcept medications.

Corcept Cares Patient Advocate Program

By signing this document, you will gain access to one-on-one support from a dedicated Corcept Cares Patient Advocate. They have previous healthcare experience and are specially trained in Cushing syndrome and Corcept medication(s). They can provide emotional support as well as information and resources on:

- **Cushing syndrome**
- **The importance of monitoring**
- **What to expect during treatment**
- **How your Corcept medication works**

Corcept Cares Patient Advocates provide information, they cannot and do not offer medical advice. Talk to your doctor regularly about your treatment, side effects, and the optimal dose for you.

For a Patient Advocate to initiate contact, it is required that you sign your HIPAA authorization below.

I hereby authorize the SPARK Specialty Pharmacy to disclose my personally identifiable health information, including but not limited to, my medical diagnosis, condition, and treatment (including prescription information), my health insurance, and my name, email, address, telephone number, and any other information necessary to connect me to Corcept Therapeutics Incorporated (Corcept), its agents, and representatives, to provide me with educational and therapy support services designed for people taking Korlym® or other Corcept medication.

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. I understand that I may revoke (withdraw) this authorization at any time by sending a written request to the SPARK Specialty Pharmacy, either by fax at 1-877-858-7746, or by email at withdraw@corceptcares.com. The SPARK Specialty Pharmacy will then no longer disclose my health information to Corcept once they have received and processed that notice. I understand that revoking this authorization will not affect any disclosure made before Corcept's receipt of my revocation. I understand that if I revoke this authorization, I will no longer be able to receive the services through the Corcept Cares Patient Advocate Program as referenced above. I understand that the revocation of this Patient Authorization will not affect my ability to get treatment from my healthcare providers or to seek payment or eligibility benefits from a health plan. I understand that if I do not revoke it earlier, this Patient Authorization will also expire one year after discontinuation of my treatment with Korlym® or other Corcept medication.

Patient Authorization (to be completed by the patient)

I have read and agree to the HIPAA Authorization to Use and Disclose Health Information as stated above.

Patient/Legal Representative Signature	Print Patient Name	Today's Date

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