



PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Cushing's – Mifepristone Preferred Specialty Management Policy

- Korlym® (mifepristone tablets – Corcept, generic)

REVIEW DATE: 04/01/2026

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

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.¹

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

POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of the Preferred Product. For all medications (Preferred and Non-Preferred), the patient is required to meet the standard *Cushing's – Mifepristone Prior Authorization Policy* criteria. The program also directs the patient to try the

generic mifepristone tablets. Requests for Non-Preferred Products will also be reviewed using the exception criteria (below). If the patient meets the standard *Prior Authorization Policy* criteria but has not tried a Preferred Product, approval for a Preferred Product will be authorized. All approvals are provided for 1 year.

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. All documentation must include patient-specific identifying information.

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

***Cushing’s - Mifepristone Preferred Specialty Management Policy* non-preferred product(s) is(are) covered as medically necessary when the following non-preferred product exception criteria is(are) met. Any other exception is considered not medically necessary.**

NON-PREFERRED PRODUCT EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Korlym	<ol style="list-style-type: none"> 1. Patient meets BOTH of the following (A <u>and</u> B): <ol style="list-style-type: none"> A) Patient meets the standard <i>Cushing’s – Mifepristone Prior Authorization Policy</i> criteria; AND B) Patient meets BOTH of the following (i <u>and</u> ii): <ol style="list-style-type: none"> i. Patient has tried generic mifepristone tablets; AND ii. 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 [documentation required]. 2. If the patient has met the standard <i>Cushing’s – Mifepristone Prior Authorization Policy</i> criteria (1A), but has <u>not</u> met exception criteria (1B) above for brand Korlym: approve generic mifepristone tablets.

REFERENCES

1. Korlym® tablets [prescribing information]. Menlo Park, CA: Corcept; September 2024.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	Effective 07/15/2024.	04/24/2024
Annual Revision	No criteria changes.	04/09/2025
Annual Revision	No criteria changes.	04/01/2026

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