Korlym

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-396-4139 FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY (*Incomplete responses may delay this request.*)

Office Contact:		**Provider Specialty:**	
Provider First Name:		**Provider Last Name:**	
Provider Phone:		**Provider Fax:**	**Provider NPI #:**
Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**
Drug Requested: ☐Brand ☐Generic	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐New medication ☐Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did member Show improvement while on therapy?	☐Yes ☐No

Diagnosis:

MEDICAL HISTORY

Does the member have Cushing's Syndrome?		☐Yes ☐No
Does the member have hyperglycemia?		☐Yes ☐No
Has the member had surgical resection previously?		☐Yes ☐No
If yes, please provide the name/type of surgery and the reason for failure:		
If no, does the member have a contraindication to surgery? If yes, please provide contraindication: ____________________		☐Yes ☐No
Female members	If the member is of childbearing potential, has she had a baseline (within 1 month) negative pregnancy test prior to initiation of therapy? Please provide date of test: ____________________	☐Yes ☐No ☐Not applicable
	If the member is of childbearing potential, is she currently using a non-hormonal, medically acceptable method of contraception?	☐Yes ☐No ☐Not applicable
	Does the member have a history of unexplained vaginal bleeding?	☐Yes ☐No
	Does the member have endometrial hyperplasia with atypia or endometrial carcinoma?	☐Yes ☐No
Is the member on concurrent long-term corticosteroid therapy?		☐Yes ☐No
Is the member on concomitant therapy with any of the following: simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, and/or tacrolimus?		☐Yes ☐No
Please provide the member's baseline HbA1c level:		
Has the member previously tried and failed conventional anti-hyperglycemic medication? Please provide chart documentation of past medications tried and failed.		☐Yes ☐No
Has the member previously tried and failed ketoconazole or metyrapone? Please provide chart documentation of past medications tried and failed.		☐Yes ☐No

Please list all medications the member has previously tried and failed or is currently using.

Medication Name	Strength	Frequency	Dates of Trial		List adverse reactions/side effects/reason for discontinuation
			Start Date	End Date	

Please be sure to complete and include the 2nd page of this form.

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Patient Name	Patient UPMC Health Plan ID Number	Patient DOB

Please be sure to complete and include this page with the 1st page of this form

Please provide any additional information which should be considered in the space below: