

**Clinical Policy: Mifepristone (Korlym)**

Reference Number: CP.PHAR.101

Effective Date: 05.01.12

Last Review Date: 02.18

Line of Business: Commercial, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

**Description**

Mifepristone (Korlym<sup>®</sup>) is a cortisol receptor blocker.

**FDA Approved Indication(s)**

Korlym is indicated to control hyperglycemia secondary to hypercortisolism in adult patients with endogenous Cushing's syndrome who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery.

Limitation(s) of use: Do not use for the treatment of type 2 diabetes mellitus unrelated to endogenous Cushing's syndrome.

**Policy/Criteria**

*Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Korlym is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria****A. Cushing's Syndrome** (must meet all):

1. Diagnosis of the following (a and b):
  - a. Uncontrolled hyperglycemia secondary to endogenous Cushing's syndrome;
  - b. Type 2 diabetes mellitus, impaired glucose tolerance or pre-diabetes as evidenced by a fasting blood glucose, oral glucose tolerance test, or hemoglobin A1c;
2. Prescribed by or in consultation with an endocrinologist;
3. Age  $\geq$  18 years;
4. Surgery to treat Cushing's syndrome was insufficient or member is not a candidate for surgery;
5. At the time of request, member does not have any of the following contraindications:
  - a. Pregnancy;
  - b. Concurrent use of simvastatin, lovastatin, or CYP3A substrates with narrow therapeutic ranges (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, tacrolimus);
  - c. Concurrent long-term corticosteroid use;
6. Dose does not exceed 1200 mg/day.

**Approval duration:****Medicaid** - 6 months

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**Commercial** – Length of benefit

**B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Cushing’s Syndrome** (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy (e.g., improved fasting blood glucose, oral glucose tolerance test, or hemoglobin A1c since initiation of therapy);
3. If request is for a dose increase, new dose does not exceed 1200 mg/day.

**Approval duration:**

**Medicaid** - 12 months

**Commercial** – Length of benefit

**B. Other diagnoses/indications** (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

**Approval duration: Duration of request 6 months (whichever is less);** or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial and CP.PMN.53 for Medicaid or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

*Appendix B: Therapeutic Alternatives*

Not applicable

**V. Dosage and Administration**

| Indication         | Dosing Regimen  | Maximum Dose |
|--------------------|---|--------------|
| Cushing’s syndrome | Starting dose is 300 mg PO QD. May increase in 300 mg increments (dose increase once every 2 to 4 weeks). | 1200 mg/day  |

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**VI. Product Availability**

Tablets: 300 mg

**VII. References**

1. Korlym Prescribing Information. Menlo Park, CA: Corcept Therapeutics, Inc.; May 2017. Available at [www.korlym.com](http://www.korlym.com). Accessed November 2017.
2. Nieman LK, Biller BMK, Findling JW et al. Treatment of Cushing’s syndrome: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2015; 100(8): 2807-2831.
3. Standards of medical care in diabetes – 2013: position statement. American Diabetes Association. Diabetes Care 2013; 36(Suppl 1): S11-S66.
4. Fleseriu M, Molitch ME, Gross C, et al. A new therapeutic approach in the medical treatment of Cushing’s syndrome: glucocorticoid receptor blockade with mifepristone. Endocr Pract. March/April 2013; 19(2): 313-326.

| Reviews, Revisions, and Approvals  | Date     | P&T Approval Date |
|--|----------|-------------------|
| <p>Added Appendix D: Special Populations Safety Background updates</p> <p>Figure 1: removed gender question to simplify line of questioning to reduce duplication of questions and prospective pregnancy testing question; added hepatic impairment question and exceeded dose question</p>  | 04.01.15 | 05.01.15          |
| <p>Policy converted to new template.</p> <p>Age requirement added per PI; specialist requirement retained per 2015 Endocrine Society guideline recommendations; max dosing added per PI; dose adjustments removed; contraindications edited per PI; continuing therapy approval duration reduced to 6 months.</p> <p>Initial therapy:</p> <ul style="list-style-type: none"> <li>• Edited requirement that members be on anti-diabetic therapy prior to initiation of Korlym to a requirement that includes lifestyle modification but not necessarily anti-diabetic medication.</li> <li>• Edited requirement that uncontrolled glucose intolerance/type 2 diabetes prior to starting Korlym be evidenced by HbA1c to a requirement that it be evidenced by fasting plasma glucose, an oral glucose tolerance test, or HbA1c per the ADA 2013 guidelines.</li> <li>• Added definition of hypokalemia to hypokalemia contraindication.</li> </ul> <p>Continuing therapy:</p> <p>Removed the 25% reduction requirement by an oral glucose tolerance test and replaced it with the</p> | 03.01.16 | 04.01.16          |

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| Reviews, Revisions, and Approvals  | Date     | P&T Approval Date |
|--|----------|-------------------|
| requirement that there is an improvement in glycemic control evidenced by fasting plasma glucose, an oral glucose tolerance test, or HbA1c.  |          |                   |
| Removed age restriction. Removed lifestyle modification requirement. Duration of approval on re-auth changed from 6 months to 12 months.   | 03.01.17 | 04.17             |
| 1Q18 annual review:<br>- Policies combined for Medicaid and Commercial lines of business.<br>- Age added. “Adherence to an anti-diabetic regimen” is removed due to verification challenge.<br>- The following contraindications are removed due to verification challenge: history of unexplained vaginal bleeding; endometrial hyperplasia with atypia or endometrial carcinoma.<br>- “Dose does not exceed 1200 mg/day or 20 mg/kg per day, whichever is less” is edited to “Dose does not exceed 1200 mg/day”. -<br>- References reviewed and updated. | 11.28.17 | 02.18             |

#### **Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to

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applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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