SPARK

SUPPORT PROGRAM FOR ACCESS AND REIMBURSEMENT FOR KORLYM

Korlym® mifepristone 300 mg Tablets

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

Patient Enrollment Form for Korlym

Effective October 1, 2015

Patient First Name _____ MI _____ Last Name _____ Date of Birth _____

Address _____ City _____ State _____ ZIP _____

Gender ☐ M ☐ F Home Phone _____ Mobile Phone _____

Preferred Method of Contact ☐ Home Phone ☐ Mobile Phone ☐ Mail Best Time to Contact _____

Primary/Secondary Insurance – Please attach a copy of both sides of the patient's insurance card(s)

Insurance Carrier _____ Customer Service Phone _____ Subscriber Name _____

Relationship to Cardholder _____ Employer Name _____ Subscriber Date of Birth _____

Subscriber ID Number _____ Policy/Employer/Group Number _____

Pharmacy Benefits – Prescription Drug Card

Insurance Carrier _____ Customer Service Phone _____ Subscriber Name _____ Bin # _____

Subscriber Date of Birth _____ Subscriber ID Number _____ Policy/Employer/Group Number _____

Diagnosis Information

Primary Diagnosis _____ ICD-10-CM Code _____

Please circle the type of Cushing's syndrome, if known:

ACTH-dependent	**ACTH-independent**	**Unknown** – E24.9
Pituitary – E24.0	Adrenal – E24.8	
Ectopic – E24.3	Adrenal carcinoma – C74.0	

Most insurance companies require the doctor's office to complete a Prior Authorization (PA). To help expedite the insurance review process, please include the following information with the PA submission.

– Test results related to diabetes, insulin resistance, or glucose intolerance (e.g., HbA_{1c}, OGTT, FPG)
– Failed/tried therapies related to diabetes or Cushing's syndrome
– Failed surgeries related to Cushing's syndrome or rationale for patients that are not candidates for surgery

The FDA requests collection of information about coexisting conditions unrelated to Cushing's syndrome. These data will be reported to the FDA without identification of individual patients.

ICD-10-CM Code/Diagnosis _____ ICD-10-CM Code/Diagnosis _____

ICD-10-CM Code/Diagnosis _____ ICD-10-CM Code/Diagnosis _____

Prescription Information: Korlym® (mifepristone) 300 mg tablets Date _____

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.

See full Prescribing Information for detailed dosing instructions.

Please check one of the dosing instructions below, or write in customized dosing directions for your patient.

___Sig: Take 1 (one) tablet (300 mg) by mouth daily for 14 days, then increase to 2 (two) tablets (600 mg) daily.	QTY 46	Initial Titration
___Sig: Take 1 (one) tablet (300 mg) by mouth daily.	QTY 30	Number of Refills _____
___Sig: Take 2 (two) tablets (600 mg) by mouth daily.	QTY 60	Number of Refills _____
___Sig: Take 3 (three) tablets (900 mg) by mouth daily.	QTY 90	Number of Refills _____
___Sig: Take 4 (four) tablets (1200 mg) by mouth daily.	QTY 120	Number of 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's Signature _____ Date _____ Prescriber NPI # _____

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

Prescriber's First Name _____ MI _____ Last Name _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ E-mail _____

Office Contact Name _____ Phone _____

SPARK

SUPPORT PROGRAM FOR ACCESS AND REIMBURSEMENT FOR KORLYM

Korlym® mifepristone 300 mg Tablets

SPARK Contact Center
1-855-4Korlym (1-855-456-7596)
Fax **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.

Corcept agrees to protect my health information by using and disclosing my information only for the reasons listed above. 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 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 be in effect for five (5) years from the date I sign this document.

Patient's Signature _____ Date _____

Print Patient's Name _____

Legally Authorized Representative's Signature (if needed) _____

Print Legally Authorized Representative's Name _____

Relationship to Patient ☐ Spouse ☐ Legal Guardian ☐ Representative per Power of Attorney

Representative's Address _____

Phone _____

Mobile Phone _____

Fax this form, along with both sides of the patient's Medical and Prescription Drug Benefit cards, to SPARK at 1-877-858-7746.
Retain a copy of this form in the patient's records.

Please see accompanying full Prescribing Information, including Boxed Warning, or go to www.korlym.com.

Korlym® mifepristone 300 mg Tablets

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

ICD-10 Codes: References and Tips for Cushing's Syndrome

Below are ICD-10 codes related to the diagnosis of Cushing's 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.

	ICD-9		ICD-10	
Cushing's Syndrome/ Hypercortisolism	Cushing's syndrome (any source)	255.0	Pituitary dependent Cushing's syndrome	E24.0
			Ectopic ACTH syndrome	E24.3
			Other Cushing's syndrome (adrenal source)	E24.8
			Cushing's syndrome (unspecified source)	E24.9
			Adrenal carcinoma	C74.0
Diabetes Mellitus/Glucose Intolerance	Secondary diabetes mellitus	249.XX	Diabetes mellitus due to underlying condition with complications	E08.8
			Diabetes mellitus due to underlying condition without complications	E08.9
			Any use of insulin	Z79.4
	Impaired fasting glucose (elevated glucose)	790.21	Impaired fasting glucose (elevated glucose)	R73.01
	Impaired glucose tolerance test (oral)	790.22	Impaired glucose tolerance test (oral)	R73.02
	Other abnormal glucose (including latent and pre-diabetes)	790.29	Other abnormal glucose (including latent and pre-diabetes)	R73.09
	Hyperglycemia unspecified	N/A	Hyperglycemia unspecified	R73.9
	Insulin resistance/hyperinsulinemia	251.10	Insulin resistance/hyperinsulinemia	E16.1

Surgery may not be an option for some patients with Cushing's 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's 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's syndrome (BMI, obesity, glucose intolerance, hypertension, etc.)

– Patients with Cushing's syndrome are at higher risk for deep vein thrombosis and infection following surgery

– Surgery may not be curative

– Patient declined surgery

SPARK

SUPPORT PROGRAM FOR ACCESS AND REIMBURSEMENT FOR KORLYM

Korlym® mifepristone 300 mg Tablets

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

How to Obtain a Speedy Insurance Decision

SPARK

Enrollment Received/ Benefits Confirmation

SPARK completes the benefits investigation within a day and will contact the prescribing office to provide all the information necessary to complete the prior authorization.

Our dedicated staff are here to help.

DOCTOR

Completing and Submitting the Prior Authorization

Most insurance companies require the doctor's office to complete a prior authorization. Here are some tips:

- Fill out the prior authorization completely (all boxes and lines)
- Provide evidence (labs or other documentation) and use ICD-10 codes for diagnosis and comorbidities
- Provide written rationale for your choice of Cushing's therapy over surgery or other therapy options
- List any failed surgeries or medical therapies related to Cushing's syndrome, if asked
- Submit quickly (within 1–2 days)

Submitting quickly and completely prevents denials and added paperwork.

SPARK

Approval and Shipment Coordination

SPARK will check with the insurance company frequently until approval (usually 1–2 days). Once approved, they will schedule a shipment and identify if the patient qualifies for any supporting copay programs.

More than 95% of patients pay $25 or less per month.

DOCTOR

SPARK

Appealing Denied Authorizations

In the case of a prior authorization denial, there are usually 3 options:

1. The office can request a peer-to-peer appeal. Peer-to-peer appeals take 5–10 minutes over the phone and rarely require follow-up paperwork or documentation. This is the most efficient method to appeal a denial and has the highest success rate.
2. SPARK can assist with the appeal. In order to help, they will need the office to fax all of the supporting medical documentation for the patient. Once received, it takes 45–60 days for processing and resolution.
3. SPARK will send temporary free drug supplies to qualifying patients during the course of insurance review.

Most appeals are successful!
Office Led: 90% SPARK Assisted: 87%