Clinical Policy: Mifepristone (Korlym)

Reference Number: CP.PHAR.101
Effective Date: 05.01.12
Last Review Date: 08.22
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Mifepristone (Korlym®) 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® 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 uncontrolled hyperglycemia secondary to endogenous Cushing's syndrome;
2. Member has type 2 diabetes mellitus, impaired glucose tolerance or pre-diabetes as evidenced by a fasting blood glucose, oral glucose tolerance test, or hemoglobin A1c;
3. Prescribed by or in consultation with an endocrinologist;
4. Age ≥ 18 years;
5. Surgery to treat Cushing's syndrome was insufficient or member is not a candidate for surgery;
6. At the time of request, member does not have any of the following contraindications (a and b):
   a. Concurrent use of drugs metabolized by CYP3A (e.g., simvastatin, lovastatin), or CYP3A substrates with narrow therapeutic ranges (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, tacrolimus);
   b. Concurrent long-term corticosteroid use;
7. Dose does not exceed 1,200 mg (4 tablets) per day.

Approval duration:

Medicaid/HIM - 6 months
Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Cushing's Syndrome (must meet all)**:**
1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy as evidenced by, including but not limited to, improvement in <u>any</u> of the following parameters: 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 1,200 mg (4 tablets) per day.

Approval duration:
Medicaid/HIM - 12 months
Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, 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, HIM.PA.154 for health insurance marketplace, 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

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Pregnancy;
  - Concurrent use of drugs metabolized by CYP3A (e.g., simvastatin, lovastatin), or CYP3A substrates with narrow therapeutic ranges (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, tacrolimus);
  - Concurrent systemic corticosteroids for lifesaving purposes (e.g., immunosuppression after organ transplantation);
  - Women with history of unexplained vaginal bleeding or endometrial hyperplasia with atypia or endometrial carcinoma;
  - Known hypersensitivity to mifepristone;
- Boxed warning(s): termination of pregnancy

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).	1,200 mg/day

VI. Product Availability

Tablets: 300 mg

VII. References

1. Korlym Prescribing Information. Menlo Park, CA: Corcept Therapeutics, Inc.; November 2019. Available at www.korlym.com. Accessed September 22, 2021.
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. Fleseriu M, Molitch ME, Gross C, et al. A new therapeutic approach in the medical treatment of Cushing's syndrome: glucorticoid receptor blockade with mifepristone. *Endocr Pract*. March/April 2013; 19(2): 313-326.
4. American Diabetes Association. Standards of medical care in diabetes—2019. Diabetes Care. 2019; 42(suppl 1): S1-S193. Updated July 31, 2019. Accessed November 5, 2019.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q18 annual review: - Policies combined for Medicaid and Commercial lines of business. - Age added. "Adherence to an anti-diabetic regimen" is removed due to verification challenge. - The following contraindications are removed due to verification challenge: history of unexplained vaginal bleeding; endometrial hyperplasia with atypia or endometrial carcinoma. -"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". - - References reviewed and updated.	11.28.17	02.18
1Q 2019 annual review: pregnancy removed as a contraindication; no significant changes; references reviewed and updated.	11.13.18	02.19
1Q 2020 annual review: no significant changes; references reviewed and updated; added HIM line of business.	11.05.19	02.20
1Q 2021 annual review: no significant changes; revised off-label policy references from HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	11.03.20	02.21
1Q 2022 annual review: no significant changes; clarified diagnosis requirement by separating into two separate requirements; references reviewed and updated.	09.22.21	02.22
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less.	04.26.22	08.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.30.22	

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 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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.