Clinical Policy: Mifepristone (Korlym)

Reference Number: CP.PHAR.101
Effective Date: 05/12
Last Review Date: 04/17

Coding Implications
Revision Log

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

Description
The intent of the criteria is to ensure that patients follow selection elements established by Centene® clinical policy for mifepristone (Korlym®).

Policy/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. Prescribed by or in consultation with an endocrinologist;
2. Diagnosis of endogenous Cushing's syndrome and all of the following:
   a. Current uncontrolled hyperglycemia (diagnosed as type 2 diabetes or impaired glucose tolerance/pre-diabetes by fasting plasma glucose, an oral glucose tolerance test, or hemoglobin A1c);
   b. The hyperglycemia is secondary to hypercortisolism;
   c. Surgery to treat Cushing's syndrome was insufficient or member is not a candidate for surgery;
   d. Adherence to an anti-diabetic regimen;
3. Prescribed dose of Korlym does not exceed 1200 mg/day or 20 mg/kg per day, whichever is less;
4. 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 (example: cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, or tacrolimus);
   c. Concurrent long term corticosteroid use;
   d. History of unexplained vaginal bleeding;
   e. Endometrial hyperplasia with atypia or endometrial carcinoma;

Approval duration: 6 months

B. Other diagnoses/indications: Refer to CP.PHAR.57 - Global Biopharm Policy.

II. Continued Approval

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

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;

2. Evidence of improved glycemic control by fasting plasma glucose, an oral glucose tolerance test, or hemoglobin A1c.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy; or
2. Refer to CP.PHAR.57 - Global Biopharm Policy**.**

Background

Description/Mechanism of Action:

Korlym (mifepristone), a cortisol receptor blocker for oral administration, acts as a selective antagonist of the progesterone receptor at low doses and blocks the glucocorticoid receptor (GR-II) at higher doses. Mifepristone has high affinity for the GR-II receptor but little affinity for the GR-I (MR, mineralocorticoid) receptor. In addition, mifepristone appears to have little or no affinity for estrogen, muscarinic, histaminic, or monoamine receptors.

Formulations:
Tablets: 300mg

FDA Approved Indication:

Korlym (mifepristone) is a cortisol receptor blocker/oral tablet 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.

Limitations of use:

- Do not use for the treatment of type 2 diabetes mellitus unrelated to endogenous Cushing's syndrome.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
S0190	Mifepristone, oral, 200 mg

Reviews, Revisions, and Approvals	Date	Approval Date
Clinical background updated	06/13	06/13
Added adrenal insufficiency question to Figure 2 Added hypersensitivity to mifepristone to App. B	06/14	06/14

Reviews, Revisions, and Approvals	Date	Approval Date
Added Appendix D: Special Populations Safety Background updates 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	04/15	05/15
Policy converted to new template. 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. Initial therapy: • 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. • 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. • Added definition of hypokalemia to hypokalemia contraindication. Continuing therapy: • Removed the 25% reduction requirement by an oral glucose tolerance test and replaced it with the requirement that there is an improvement in glycemic control evidenced by fasting plasma glucose, an oral glucose tolerance test, or HbA1c.	03/16	04/16
Removed age restriction. Removed lifestyle modification requirement. Duration of approval on re-auth changed from 6 months to 12 months.	03/17	04/17

References

1. Korlym Prescribing Information. Menlo Park, CA: Corcept Therapeutics, Inc.; October 2016. Available at www.korlym.com. Accessed March 17, 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: glucorticoid receptor blockade with mifepristone. Endocr Pract. March/April 2013; 19(2): 313-326.

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.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.