PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Oral) – Lifyorli Prior Authorization Policy
- Lifyorli™ (relacorilant capsules – Corcept)

REVIEW DATE: 04/01/2026

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Lifyorli, a glucocorticoid receptor antagonist, is indicated **in combination with nab-paclitaxel for the treatment of platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer** in adults who have received one to three prior systemic treatment regimens, at least one of which included bevacizumab.[1]

Guidelines

The National Comprehensive Cancer Network (NCCN) ovarian cancer (including fallopian tube cancer and primary peritoneal cancer) clinical practice guidelines (version 4.2026 – April 10, 2026) recommend a variety of treatment options as recurrence therapy for platinum-resistant disease.[2] Lifyorli + albumin-bound paclitaxel (for patients who have been treated with up to three lines of therapy and prior bevacizumab) is listed amongst the "Preferred" cytotoxic therapies (category 2A); there is a footnote that states that steroid premedication should not be used.

Some of the other "Preferred" cytotoxic therapies include docetaxel, gemcitabine, liposomal doxorubicin ± bevacizumab, weekly paclitaxel ± bevacizumab, oral cyclophosphamide + bevacizumab, and topotecan ± bevacizumab (category 2A). Elahere® (mirvetuximab soravtansine-gynx intravenous infusion) is recommended as targeted therapy for folate receptor alpha (FRα)-expressing tumors (≥ 75% positive tumor cells) [category 1].

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Lifyorli. All approvals are provided for the duration noted below.

Lifyorli™ (relacorilant capsules - Corcept) is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. **Ovarian, Fallopian Tube, or Primary Peritoneal Cancer.** Approve for 1 year if the patient meets ALL of the following (A, B, C and D):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has platinum-resistant disease; AND
   - **C)** Patient has tried at least one systemic regimen that includes bevacizumab; AND
     Note: Examples of a systemic regimen include one or more of the following agents: carboplatin, cisplatin, docetaxel, doxorubicin, gemcitabine, nab-paclitaxel, oxaliplatin, or paclitaxel.
   - **D)** The medication is used in combination with nab-paclitaxel.

CONDITIONS NOT COVERED

Lifyorli™ (relacorilant capsules - Corcept) is(are) considered not medically necessary for ANY other use(s). Criteria will be updated as new published data are available.

REFERENCES

1. Lifyorli™ capsules [prescribing information]. Redwood City, CA: Corcept Therapeutics; March 2026.
2. The NCCN Ovarian Cancer Including Fallopian Tube Cancer and Primary Peritoneal Cancer Clinical Practice Guidelines in Oncology (version 4.2026 – April 10, 2026). © 2026 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 15, 2026.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	04/01/2026
Update	04/15/2026: The guidelines portion of the overview section was updated to include the National Comprehensive Cancer Network recommendation for Lifyorli	N/A