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Mifepristone (Korlym®)

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Related Coverage Resources

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. 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.

Overview

This policy supports medical necessity review for mifepristone (Korlym®).

Receipt of sample product does not satisfy any criteria requirements for coverage.

Medical Necessity Criteria

Mifepristone (Korlym) is considered medically necessary when ONE of the following is met:

- 1. Endogenous Cushing's Syndrome. Individual meets ALL of the following criteria:
A. Age 18 years or older
B. Korlym is being used to control hyperglycemia secondary to hypercortisolism in individuals who have type 2 diabetes mellitus or glucose intolerance
C. The individual is not a candidate for surgery or surgery has not been curative
D. Medication is prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome.

2. **Endogenous Cushing's Syndrome – Individuals Awaiting Surgery.** Individual meets **BOTH** of the following criteria:
  - A. Age 18 years or older
  - B. Medication is prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of endogenous Cushing's syndrome.
  
3. **Endogenous Cushing's Syndrome – Individuals Awaiting Therapeutic Response After Radiotherapy.** Individual meets **BOTH** of the following criteria:
  - A. Age 18 years or older
  - B. Medication is prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of endogenous Cushing's syndrome

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

## Reauthorization Criteria

Continuation of mifepristone (Korlym<sup>®</sup>) is considered medically necessary for **ALL** covered diagnoses when the above medical necessity criteria are met **AND** there is documentation of beneficial response (such as an improvement in fasting glucose, oral glucose tolerance, or hemoglobin A1c results).

## Authorization Duration

Initial and reauthorization approval duration:

- Endogenous Cushing's Syndrome: up to 12 months
- Endogenous Cushing's Syndrome – Individuals Awaiting Surgery: up to 6 months
- Endogenous Cushing's Syndrome – Individuals Awaiting Therapeutic Response After Radiotherapy: up to 6 months

## Conditions Not Covered

Any other use is considered experimental, investigational or unproven, including the following (this list may not be all inclusive):

1. **Type 2 Diabetes Not Associated with Endogenous Cushing's Syndrome.** Korlym should not be used for the treatment of type 2 diabetes unrelated to endogenous Cushing's syndrome.<sup>1</sup>
  
2. **Psychotic Features of Psychotic Depression.** Mifepristone has been used to treat the psychotic features of psychotic depression. Individual trials have demonstrated variable efficacy results.<sup>6,7</sup> In some of the studies comparing mifepristone with placebo, various statistically significant improvements in psychiatric symptoms have been noted with mifepristone relative to placebo; however, the methodology and statistical analyses of some studies have been questioned. Data are inconclusive.

## Background

### OVERVIEW

Korlym, a cortisol receptor blocker, is indicated to control hyperglycemia secondary to hypercortisolism in adults with **endogenous Cushing's syndrome** who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery.<sup>1</sup>

*Korlym should not be used for the treatment of type 2 diabetes mellitus unrelated to endogenous Cushing's syndrome.*<sup>1</sup>

### **Disease Overview**

Cushing's syndrome refers to the general state of excessive levels of cortisol (hypercortisolism) in the blood.<sup>2,3</sup> Hypercortisolism can occur for reasons that are either endogenous or exogenous in nature (e.g., Cushing's disease, cortisol-containing medications, adrenal gland tumor, certain cancers). Cushing's disease (hypercortisolism caused by pituitary adenomas) is the most common type of adrenocorticotropic hormone (ACTH)-dependent Cushing's syndrome. Treatment for Cushing's syndrome requires a multi-modal approach. The goals of treatment are normalization of cortisol excess, long-term disease control, avoidance of recurrence, and reversal of clinical features.<sup>4</sup>

### **Guidelines**

The Endocrine Society published clinical practice guidelines (2015) for the treatment of Cushing's syndrome.<sup>5</sup> First-line treatment involves resection of the tumor, unless surgery is not possible or is unlikely to meaningfully reduce excess glucocorticoid levels. In patients with ACTH-dependent Cushing's syndrome who underwent non-curative surgery or for whom surgery was not possible, the guidelines advocate several second-line therapies (e.g., repeat transsphenoidal surgery, radiotherapy, medical therapy, and bilateral adrenalectomy). For Cushing's disease, the guidelines recommend all medical therapies as second-line options after transsphenoidal surgery: steroidogenesis inhibitors (ketoconazole tablets, Metopirone<sup>®</sup> [metyrapone capsules], Lysodren<sup>®</sup> [mitotane tablets], etomidate injection) in patients either with or without radiotherapy/radiosurgery; pituitary-directed medical treatments (cabergoline tablets, Signifor<sup>®</sup> [pasireotide subcutaneous injection]) in patients who are not surgical candidates or who have persistent disease; and Korlym<sup>®</sup> (mifepristone tablets) in patients with diabetes or glucose intolerance who are not surgical candidates or who have persistent disease after transsphenoidal surgery.

## **References**

1. Korlym<sup>®</sup> tablets [prescribing information]. Menlo Park, CA: Corcept; March 2020.
2. Sharma ST, Nieman LK, Feelders RA. Cushing's syndrome: epidemiology and developments in disease management. *Clin Epidemiol.* 2015;7:281–293.
3. Tritos NA, Biller BM. Advances in medical therapies for Cushing's syndrome. *Discov Med.* 2012;13(69):171-179.
4. Biller BMK, Grossman AB, Stewart PM, et al. Treatment of adrenocorticotropic-dependent Cushing's syndrome: A consensus statement. *J Clin Endocrinol Metab.* 2008;93:2454-2462.
5. Nieman LK, Biller BM, Findling JW. Treatment of Cushing's Syndrome: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab.* 2015;100(8):2807-2831.
6. DeBattista C, Belanoff J, Glass S, et al. Mifepristone versus placebo in the treatment of psychosis in patients with psychotic major depression. *Biol Psychiatry.* 2006;60:1343-1349.
7. Flores BH, Kenna H, Keller J, et al. Clinical and biological effects of mifepristone treatment for psychotic depression. *Neuropsychopharmacology.* 2006;31:628-636

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