AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Mifepristone (Korlym®)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for mifepristone (Korlym®). Payment will be considered for patients when the following is met: 1) The patient is 18 years of age or older; and 2) Has a diagnosis of endogenous Cushing's Syndrome with hyperglycemia secondary to hypercortisolism in patients with Type 2 Diabetes or glucose intolerance; 3) Patient must have failed surgery or is not a candidate for surgery; 4) Prescriber is an endocrinologist; 5) Female patients of reproductive age must have a negative pregnancy test confirmed within the last 7 days and must use a non-hormonal method of contraception during treatment and for one month after stopping treatment.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Non-Preferred:

☐ **Korlym®**

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

Has patient failed surgery? ☐ Yes ☐ No

If no, indicate why not a candidate for surgery:

Is Prescriber an Endocrinologist? ☐ Yes ☐ No

If no, note consultation with Endocrinologist:

Consultation date: Physician name: Physician phone:

If female of child-bearing years, confirmed negative serum pregnancy test? ☐ Yes ☐ No

Date of pregnancy test: Specify plan for contraception:

Possible drug interactions/conflicting drug therapies:

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Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.