Lifyorli™ (relacorilant) 100 mg, 25 mg capsules

Lifyorli SUPPORT™
We're here if you need us

Support is available if you need help getting your eligible patients started with LIFYORLI

LIFYORLI Support provides assistance navigating your patients' coverage and available affordability options.

Complete, sign, and submit the pages of this form as needed, based on your required services:

Coverage Support

Benefit investigation, prior authorization, and/or appeal support

Submit Page 1

- Prescriber signature is required *once* - **Page 1, Section 8**
- Patient signs *once* - **Page 1, Section 9A** *(first signature only)*

LIFYORLI Quick Start Program

*LIFYORLI at no cost for eligible patients who experience a delay in coverage**

Submit Pages 1 and 2

- Prescriber signature required *twice* - **Page 1, Section 8** and **Page 2, Section 9**
- Patient signs *once* - **Page 1, Section 9A** *(first signature only)*

LIFYORLI Patient Assistance Program (PAP)

*LIFYORLI at no cost for patients who need financial assistance and meet eligibility requirements**

Submit Pages 1 and 3

- Prescriber signature required *twice* - **Page 1, Section 8** and **Page 3, Section 9**
- Patient signs *twice* - **Page 1, Section 9A** and **9B**

Submit completed page(s) to 1-844-854-3967

To complete and submit this form electronically

LIFYORLIenroll.com

For patients to complete their consent online

LIFYORLIeconsent.com

1-85-LIFYORLI (855-439-6754) | **Monday-Friday, 8 AM to 8 PM ET** | **LIFYORLIhcp.com/support**

*See Page 2 for details.

LIFYORLI™, LIFYORLI Support™, and the LIFYORLI™ logo are trademarks of Corcept.
Corcept and the Corcept logo are registered trademarks.
All other trademarks are the property of their respective owners.
© 2026 Corcept. All rights reserved. US-LIF-26-0014 06-26

Lifyorli™ (relacorilant) 100 mg, 25 mg capsules | Lifyorli SUPPORT™ We're here if you need us

Enrollment Form

Use this form to enroll your patients in LIFYORLI Support for help accessing and affording LIFYORLI.

1 LIFYORLI SUPPORT CASE MANAGER CAN HELP WITH THE FOLLOWING:

- **Coverage Support**
- **Quick Start Program**
- **Copay Assistance**
- **Patient Assistance Program**
- **Provide Educational Resources**

2 Patient Information *(Required)*

Patient Name (First, Last): _____ Date of Birth: MM/DD/YYYY

Mobile: _____ Home: _____ Work: _____

Preferred Phone: ○ Mobile ○ Home ○ Work OK to Leave Message: ○ Yes ○ No

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Preferred Language: ○ English ○ Spanish ○ Other: _____

3 Caregiver Information *(Optional)*

Contact Caregiver Instead of Patient: ○ Yes ○ No Caregiver Name: _____

Mobile: _____ Home: _____ Work: _____

Preferred Phone: ○ Mobile ○ Home ○ Work OK to Leave Message: ○ Yes ○ No

4 Prescriber Information *(Required)*

Prescriber Name (First, Last): _____ NPI: _____

Facility Name: _____ Primary Office Contact Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Contact Phone: _____ Office Contact Email: _____ Fax: _____

5 Clinical Information *(Required)*

Does the patient have a diagnosis consistent with the FDA-approved indication? ○ Yes ○ No

Patient Diagnosis: _____ ICD-10 Code(s): _____ Treatment Start Date: MM/DD/YYYY

# of Prior Treatments: _____ Prior Treatments (including bevacizumab): _____

6 Insurance Information *(Required)*

○ Attach a copy of both sides of patient's insurance card(s) (*prescription insurance information is preferred*) ○ Uninsured

OR Provide Insurance Information: Plan Name: _____ Group Number: _____ Policy ID/Member Number: _____

7 Preferred Specialty Pharmacy *(Select one)*

○ In-Office or Hospital/Health System Pharmacy Name: _____

Phone: _____ Fax: _____

○ Authorized In-Network Pharmacy (*Onco360 Specialty Pharmacy*)

8 Healthcare Provider (HCP) Consent *(Required)*

I have read and agree to the **Healthcare Provider Certification on Page 5**.

HCP Name (print): _____

SIGN HERE HCP Signature: _____ Date: MM/DD/YYYY

9 Patient Authorization

By signing below, I authorize release of health information outlined on **Page 4 Patient Authorization to Share Protected Health Information (PHI).**

Patient/Authorized Representative* Name (print): _____

○ Yes, I want to receive updates via text about LIFYORLI SUPPORT and educational resources at the number I provided.

A SIGN HERE Patient/Authorized Representative* Signature: _____ Date: MM/DD/YYYY

For Patient Assistance Program (PAP) ONLY: I give permission to use my income information and I agree to the PAP certification as outlined **on Page 3**.

Patient/Authorized Representative* Name (print): _____

B SIGN HERE Patient/Authorized Representative* Signature: _____ Date: MM/DD/YYYY

1-85-LIFYORLI (855-439-6754) | **Monday-Friday, 8 AM to 8 PM ET** | **LIFYORLIhcp.com/support**

Submit completed page(s) to **1-844-854-3967**

* An Authorized Representative is a person with legal authority to make healthcare decisions on behalf of the individual.

LIFYORLI™, LIFYORLI Support™, and the LIFYORLI™ logo are trademarks of Corcept. Corcept and the Corcept logo are registered trademarks. All other trademarks are the property of their respective owners. © 2026 Corcept. All rights reserved. US-LIF-26-0014 06-26

LIFYORLI Quick Start Program*

LIFYORLI Quick Start Program offers up to two months of LIFYORLI at no cost for eligible patients who experience a delay in obtaining coverage from their insurance.

Eligibility Criteria:

- Be prescribed LIFYORLI for an FDA-approved use
- Live in the US or a US Territory
- Have prescription drug insurance
- Experience a delay in getting a coverage decision from insurance (≥5 days) and
- Be working with insurance to get a coverage decision
- Eligible patients will receive one 28-day supply as prescribed by their healthcare provider. If there is a further delay in coverage, patients may receive another 28-day supply refill.

*Full Terms and Conditions apply.

10 Quick Start Program Prescription *(Optional – complete this section only for Quick Start prescription)*

○ Separate Prescription is attached **OR**

Complete prescription information section below

Patient Name: _____ Date of Birth: MM/DD/YYYY

Current Medications: _____

Allergies to Medications: _____

LIFYORLI (relacorilant)

Directions for Administration – *Recommended Dose*

○ **SIG**: Take 150 mg PO at the same time of day with food the day before, the day of, and the day after each nab-paclitaxel (PACLitaxel Protein-Bound Particles) infusion which is given on Day 1, Day 8, and Day 15 of a 28-day cycle.

Dosage Strength: 150 mg **Days Supply:** 28 (9-Dose Supply) **Refills:** _____

Note to pharmacist: When combined with LIFYORLI, nab-paclitaxel is dosed approximately 80 mg/m^2 IV over 30 minutes on Days 1, 8, and 15 of each 28-day cycle.

Additional Instructions: _____

_____

NOTE: LIFYORLI will be delivered to the mailing address on Page 1, Section 2 unless a different shipping address is provided.

Prescriber Name (print): _____

SIGN HERE **Prescriber Signature:** _____ **Date:** MM/DD/YYYY

Note: If separate prescription is attached, prescriber signature is not required on this page.

LIFYORLI™, LIFYORLI Support™, and the LIFYORLI™ logo are trademarks of Corcept.
Corcept and the Corcept logo are registered trademarks.
All other trademarks are the property of their respective owners.
© 2026 Corcept. All rights reserved. US-LIF-26-0014 06-26

Corcept Patient Assistance Program (PAP)*

The Corcept PAP is a charitable program that provides LIFYORLI at no cost to patients who need financial assistance and meet eligibility requirements.

Eligibility Criteria:

To qualify to receive LIFYORLI at no cost through the Corcept Patient Assistance Program (Corcept PAP), patients must meet the following eligibility criteria:

- Be prescribed LIFYORLI
- Live in the US or a US Territory
- Have no insurance or have insurance that doesn't fully cover LIFYORLI
- Be unable to afford the cost of LIFYORLI
- Have no other financial support available (not eligible for Medicare Extra Help, State's Medicaid or any other financial support options)

Meet the household income limits for the program:

Number of People in Household	Maximum Annual Household Income Allowed†
	$79,800
	$108,200
	$136,600
	$165,000

If your household income is at or below the amount listed for your household size, you may be able to qualify.

*Full Terms and Conditions apply.

† These limits are based on federal guidelines. To learn more, visit: www.aspe.hhs.gov/poverty

11 Patient Assistance Program Prescription *(Optional - only required if applying for Patient Assistance Program)*

○ Separate Prescription is attached **OR**

Complete prescription information section below

Patient Name: _____ Date of Birth: MM/DD/YYYY

Current Medications: _____

Allergies to Medications: _____

LIFYORLI (relacorilant)

Directions for Administration – *Recommended Dose*

○ **SIG**: Take 150 mg at the same time of day with food the day before, the day of, and the day after each nab-pac (PACLitaxel Protein-Bound Particles) infusion which is given on Day 1, Day 8, and Day 15 of a 28-day cycle.

Dosage Strength: 150 mg **Days Supply:** 28 (9-Dose Supply) **Refills:** _____

Note to pharmacist: When combined with LIFYORLI, nab-paclitaxel is dosed approximately 80 mg/m^2 IV over 30 minutes on Days 1, 8, and 15 of each 28-day cycle.

Additional Instructions: _____

_____

NOTE: LIFYORLI will be delivered to the mailing address on Page 1, Section 2 unless a different shipping address is provided.

Prescriber Name (print): _____

SIGN HERE **Prescriber Signature:** _____ **Date:** MM/DD/YYYY

Note: If separate prescription is attached, prescriber signature is not required on this page.

LIFYORLI™, LIFYORLI Support™, and the LIFYORLI™ logo are trademarks of Corcept.
Corcept and the Corcept logo are registered trademarks.
All other trademarks are the property of their respective owners.
© 2026 Corcept. All rights reserved. US-LIF-26-0014 06-26

12 Patient Authorization to Share Protected Health Information and Provision of LIFYORLI Support Patient Support Services

By signing on **Page 1, Section 9A of the Patient Enrollment Form for LIFYORLI Support**, a Corcept Therapeutics Incorporated program, I give permission for all of my healthcare providers, pharmacies, service providers, health plans, and health insurer(s) and their contractors to disclose any and all necessary information, including, but not limited to, my medical prescriptions, medical diagnosis, condition, or treatment, financial documents, prescription coverage, health records and identifying information including but not limited to name, date of birth, address, email address, and telephone number (collectively, "Protected Health Information" or "PHI") to Corcept Therapeutics Incorporated and all of its affiliates, service providers and agents (collectively, "Corcept"). My PHI will be shared with Corcept for the purpose of providing me with support and information to help me access LIFYORLI (relacorilant) or other Corcept medicine, which may include the following:

(1) Providing benefits investigations and/or verification reimbursement support including identification of my health plan or insurer's prior authorization requirements, identification of my insurer's requirements for appealing a denied claim,

(2) determining my eligibility for and helping me access financial assistance resources if I am eligible;

(3) Coordinating the dispensing and delivery of a Corcept medicine;

(4) Providing me with disease management and other educational materials as well as information about Corcept's products and services, which may include sending me surveys about my experience with Corcept's products and services;

(5) Providing me with educational information, resources and support resources on my treatment and/or condition through **LIFYORLI Support** program;

(6) Conducting internal quality and business analysis to evaluate and improve Corcept's operations and services.

This authorization is voluntary, but if I do not sign this authorization, I cannot take part in the Program. I am not required to sign this authorization. If I do not sign this authorization, it will not affect my medical care or my access to LIFYORLI medication.

I understand and acknowledge that while Corcept will make good faith efforts to keep PHI private, once PHI is disclosed to third parties it may no longer be protected by federal and state privacy and security laws and may be subject to redisclosure. I may cancel my authorization at any time by sending a written request to LIFYORLI Support at lifyorlisupport@connectmed.com. Such revocation will not affect my ability to get treatment from my health care providers or to seek payment or benefits from a health plan or insurer. However, if I cancel this authorization, I can no longer participate in the programs and/or services administered by Corcept such as the LIFYORLI Support Program. If I cancel this authorization, Corcept will stop using or disclosing my PHI except as necessary to end participation, but such revocation will not affect uses and disclosures of PHI made in reliance upon this authorization. If I do not withdraw authorization, I understand that this authorization will remain valid for three (3) years (or at such lesser time as state law may require). I understand that I am entitled to receive a copy of this authorization.

Patient or Patient's Authorized Representative should sign on Page 1, Section 9A to provide Patient Authorization to Share Protected Health Information (PHI).

LIFYORLI™, LIFYORLI Support™, and the LIFYORLI™ logo are trademarks of Corcept.
Corcept and the Corcept logo are registered trademarks.
All other trademarks are the property of their respective owners.
© 2026 Corcept. All rights reserved. US-LIF-26-0014 06-26

13 Healthcare Provider Certification

By signing Page 1, Section 8 of this form, I certify that:

(1) The above therapy (or medicine) is medically necessary;

(2) I certify that I am the prescriber who has prescribed LIFYORLI and that the information provided is accurate to the best of my knowledge;

(3) I understand that Corcept and its affiliates will use this information to assess the patient's eligibility for participation in LIFYORLI patient support programs and resources;

(4) For Pharmacy Triage: I authorize LIFYORLI Support to act on my behalf for the purpose of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan (if applicable).

(5) I have not received, nor will I seek or accept reimbursement from any federal, state, or private payers for any drug provided for my patient by either the Quick Start or the Patient Assistance Program (PAP);

(6) I understand that changes to my patient's insurance or financial status may impact their program eligibility and I agree to notify LIFYORLI Support if I become aware of any such changes;

HCP should sign on Page 1, Section 8 to provide certification.

14 Patient Certification for Participation in Corcept Patient Assistance Program

By signing Page 1, Section 9B of the Patient Enrollment Form for LIFYORLI Support, I hereby certify that I cannot afford my medication and agree to provide Corcept with all requested information to determine my eligibility in PAP.

I certify that all information provided to Corcept to determine my eligibility in PAP is true, correct, and accurate to the best of my ability, and I will verify any of the information provided to PAP upon request. I will promptly contact Corcept if my financial status or insurance coverage changes. Any medicines supplied by PAP shall not be sold, traded, bartered, or otherwise transferred. If I am a Medicare Part D participant, I will not seek to have any medicine or any cost from it counted in my Medicare Part D true out-of-pocket costs (TrOOP) for prescription drugs. I will not submit claims, seek reimbursement or credit for the medicine(s) from my prescription insurance provider or payor, including Medicare Part D plans. Corcept reserves the right to change or cancel the PAP, or terminate my enrollment, at any time. The support provided through this program is not contingent on any future purchase.

I give permission to Corcept to combine or aggregate any information collected about me with information PAP may collect from other sources for the purpose of providing or administering PAP. I understand and agree to the Patient Authorization to Share Protected Health Information. I authorize Corcept to contact me by mail, email, and phone at the number(s), email(s), and address(es) provided on this enrollment form so that PAP can provide me with access to the products which I am prescribed. If I agreed to receive text messages in accordance with the consent on page 1, then Corcept may also contact me via text.

Patient should sign on Page 1, Section 9B to provide certification.

LIFYORLI™, LIFYORLI Support™, and the LIFYORLI™ logo are trademarks of Corcept.
Corcept and the Corcept logo are registered trademarks.
All other trademarks are the property of their respective owners.
© 2026 Corcept. All rights reserved. US-LIF-26-0014 06-26