Relacorilant: FDA Approved GR Antagonist for Ovarian Cancer

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Executive Summary

Relacorilant (brand **LIFYORLI™**) is a first-in-class selective glucocorticoid receptor (GR) antagonist recently approved by the U.S. Food and Drug Administration (FDA) for use **in combination with nab-paclitaxel** in platinum-resistant ovarian cancer ([1] www.fda.gov) ([2] www.aol.com). In an open-label Phase III trial (ROSELLA, N=381), the addition of relacorilant significantly extended overall survival (OS) compared to chemotherapy alone: median OS was **16.0 months versus 11.9 months** (hazard ratio [HR] 0.65; 95% CI 0.51–0.83; p=0.0004) ([3] www.fda.gov) ([4] www.sciencedirect.com). Progression-free survival (PFS) was also improved (6.5 vs. 5.5 months; HR 0.70; p=0.0076) ([3] www.fda.gov) ([4] www.sciencedirect.com). These gains in survival were achieved without requiring any tumor biomarker selection ([5] www.sciencedirect.com). Relacorilant works by **blocking cortisol/GR signaling**, which preclinical data show can drive chemotherapy resistance (via upregulation of anti-apoptotic genes like SGK1 and DUSP1) ([6] www.tandfonline.com) ([7] ichgcp.net). As such, relacorilant restores chemosensitivity and thereby potentiates the effect of nab-paclitaxel. The approved dosing is 150 mg orally on the day *before*, *of*, and *after* each weekly nab-paclitaxel infusion ([8] ascopost.com) ([9] www.aol.com).

The ROSELLA trial's findings represent a new standard for platinum-resistant ovarian cancer: a nearly 5-month median OS improvement and a 35% reduction in risk of death ([3] www.fda.gov) ([2] www.aol.com). Adverse events in the relacorilant combination arm were largely hematologic and gastrointestinal (e.g. neutropenia, anemia, fatigue, nausea) ([10] www.sciencedirect.com) ([11] www.aol.com), generally similar in frequency to paclitaxel alone ([12] www.sec.gov) ([10] www.sciencedirect.com). Notably, relacorilant is contraindicated in patients requiring chronic steroid therapy (e.g. **"patients who rely on steroid medications to survive"**) ([13] dailymed.nlm.nih.gov) ([11] www.aol.com), because blocking GR can precipitate adrenal insufficiency or exacerbate steroid-treated conditions ([14] dailymed.nlm.nih.gov) ([11] www.aol.com).

In summary, LIFYORLI™ (relacorilant) adds a novel hormonal mechanism to the ovarian cancer armamentarium. It offers a significant survival benefit when combined with chemotherapy in a setting with historically few options ([15] www.sciencedirect.com) ([4] www.sciencedirect.com). Analysts project strong market uptake (peak sales ~$550M ([16] www.aol.com)), and the drug was approved well ahead of its target date ([17] ascopost.com) ([11] www.aol.com). Ongoing and future studies are exploring its use in other GR-driven malignancies and in combination with additional agents, including immune checkpoint inhibitors ([18] www.sciencedirect.com) ([19] www.sciencedirect.com). For clinicians and patients, relacorilant offers a new, evidence-based therapy to extend survival and quality of life in advanced ovarian cancer.

Introduction and Background

Ovarian Cancer and Platinum Resistance

Epithelial ovarian cancer is a major gynecologic malignancy with high mortality, causing roughly **207,000 deaths worldwide in 2020** ([20] www.sciencedirect.com). Initially, ovarian tumors are commonly treated with platinum-based chemotherapy (e.g. carboplatin) often combined with taxanes; however, disease relapse is frequent. In fact, *approximately 70% of patients* relapse after first-line therapy ([20] www.sciencedirect.com). When the cancer recurs, one important classification is based on the timing of relapse: **"platinum-resistant" disease** refers to progression within 6 months of completing platinum therapy ([21] www.sciencedirect.com). By contrast, progression beyond 6 months is considered "platinum-sensitive." Platinum-resistant ovarian cancer historically has a very poor prognosis, with median survival generally on the order of **10–16 months** ([15] www.sciencedirect.com). In this setting, treatment options are limited. Standard regimens include non-platinum cytotoxic agents (such as paclitaxel, pegylated liposomal doxorubicin, gemcitabine) alone or with bevacizumab (a VEGF inhibitor).Weekly paclitaxel is among the most active of these approaches in platinum-resistant disease, yielding median progression-free survival (PFS) of only ~3.9–5.5 months and

objective response rates of ~26–32% ([22] www.sciencedirect.com). Nab-paclitaxel (albumin-bound paclitaxel) shows similar efficacy and is included in treatment compendia for this indication ([22] www.sciencedirect.com). Nonetheless, the *overall survival (OS)* for platinum-resistant ovarian cancer remains bleak, underscoring the need for novel therapies to overcome resistance ([15] www.sciencedirect.com) ([4] www.sciencedirect.com).

Biology of Glucocorticoid Signaling in Cancer

Glucocorticoids (cortisol and synthetic analogues like dexamethasone) are widely used in oncology for symptom control and to pre-medicate against chemotherapy side effects. However, an expanding body of research indicates that **glucocorticoid receptor (GR) activation can paradoxically promote tumor cell survival and chemoresistance** in certain epithelial cancers ([6] www.tandfonline.com) ([7] ichgcp.net). In ovarian cancer models, GR activation has been shown to reduce sensitivity to chemotherapy by up-regulating anti-apoptotic pathways. For example, Conzen et al. demonstrated that in ovarian cancer cells and in patients, glucocorticoids induce expression of anti-survival genes SGK1 (serum/glucocorticoid-regulated kinase-1) and DUSP1/MKP1 (dual specificity phosphatase 1) ([7] ichgcp.net). In a randomized clinical study, preoperative intravenous dexamethasone given to ovarian cancer patients increased tumor SGK1 mRNA by over six-fold and MKP1 by eight-fold relative to controls ([7] ichgcp.net) ([23] ichgcp.net). These genes blunt chemotherapy-induced apoptosis (e.g. by modulating Bcl-2 and FOXO3a signaling) ([24] pmc.ncbi.nlm.nih.gov) ([7] ichgcp.net). Similarly, in models of breast and ovarian cancer, GR activation was associated with poor outcomes, whereas GR antagonism promoted apoptosis ([25] pmc.ncbi.nlm.nih.gov). In an analysis across multiple solid tumors, high GR expression was linked to worse survival: in ovarian cancer specifically, GR protein was detected in about 39% of invasive tumors, and higher GR levels predicted shorter PFS ([26] www.sciencedirect.com) ([19] www.sciencedirect.com).

Overall, endogenous or exogenous glucocorticoids tend to induce pro-survival signals in ovarian cancer cells, counteracting the effects of cytotoxic drugs ([6] www.tandfonline.com) ([7] ichgcp.net). This mechanistic insight spurred investigation of GR antagonists as chemo-sensitizing agents. In practice, standard paclitaxel regimens include steroids to prevent hypersensitivity reactions, potentially aggravating this effect. The idea arose that an estrogenic steroid antagonist given around chemotherapy infusions could *block* the cortisol-mediated survival signals and thereby restore chemosensitivity ([6] www.tandfonline.com) . Thus began the development of selective glucocorticoid receptor antagonists (SGRAs) like relacorilant.

Previous GR-Targeting Approaches

The concept of blocking GR in cancer is not entirely new. Mifepristone (RU-486) is a non-selective steroid receptor antagonist with activity at both GR and progesterone receptor (PR). It was tested in ovarian cancer in early studies, but its efficacy was modest and confounded by anti-progestational effects ([27] www.tandfonline.com). Mifepristone monotherapy yielded an overall response rate of ~26% in a phase II trial ([27] www.tandfonline.com), but it also has off-target effects and side effects (endometrial changes, incomplete GR blockade, etc.). Relacorilant (CORT125134) was specifically engineered to selectively antagonize GR without significant PR or progesterone blockade, aiming to improve tolerability and efficacy ([28] www.sciencedirect.com) ([29] www.sciencedirect.com). By avoiding progesterone receptor, relacorilant also can be tested in combination with chemotherapy without interfering with any progestin pathways. Its chemical optimization was guided by Corcept Therapeutics' prior experience with mifepristone (Korlym®) in Cushing's syndrome.

Preclinical studies with relacorilant (often termed a Selective GR Modulator, SGRM) confirmed the rationale. In xenograft models of ovarian, breast, and other cancers, relacorilant given around the time of a taxane significantly delayed tumor growth compared to paclitaxel alone ([30] pmc.ncbi.nlm.nih.gov). Notably, Pamela Munster et al. reported that dexamethasone suppressed the cytotoxic killing of ovarian cancer cells by paclitaxel, but adding relacorilant overcame this effect in vitro ([31] pmc.ncbi.nlm.nih.gov) ([32] pmc.ncbi.nlm.nih.gov). In animal models, relacorilant combined with nab-paclitaxel significantly inhibited tumor progression versus chemotherapy alone ($p<0.0001$) ([30] pmc.ncbi.nlm.nih.gov).

These and other preclinical data led to early-phase clinical trials combining relacorilant with taxanes (and even other agents like enzalutamide in prostate cancer).

Relacorilant: Mechanism of Action and Pharmacology

Relacorilant is an orally-active small molecule **glucocorticoid receptor antagonist** (SGRA). Unlike non-selective antagonists, it does *not* block the progesterone receptor. Upon administration, relacorilant competitively binds the GR in tissues, preventing cortisol and other glucocorticoids from activating pro-survival gene expression programs ([28] www.sciencedirect.com) ([19] www.sciencedirect.com). The dosing schedule used in trials was specifically designed to "pulse" the GR blockade around chemotherapy infusions: 150 mg relacorilant was given the day *before*, *the day of*, and *the day after* each paclitaxel infusion ([8] ascopost.com) ([33] www.sciencedirect.com). This intermittent schedule aims to maximize GR antagonism during peak cortisol exposure from stress or steroid premedication, while allowing recovery in between cycles.

Pharmacologically, relacorilant has linear kinetics and is primarily metabolized by cytochrome P450 enzymes. Concomitant use with strong CYP3A4 or CYP2C8 inducers or inhibitors can alter relacorilant exposure ([34] dailymed.nlm.nih.gov). No clinically significant pharmacokinetic differences were observed by age, body weight (26–128 kg), race, or mild hepatic or renal impairment ([35] dailymed.nlm.nih.gov). In the ROSELLA regimen, no written prophylactic corticosteroids are given (nab-paclitaxel does not require steroid premedication), so the antagonism is focused on endogenous cortisol and any supportive steroids the patient may use. The recommended dosage is **150 mg orally once daily** for three days per chemotherapy cycle ([8] ascopost.com) ([9] www.aol.com).

Biologically, by binding GR and blocking cortisol's action, relacorilant **neutralizes cortisol-mediated stress signaling** in the tumor microenvironment. Cortisol typically activates GR target genes like SGK1 and DUSP1, which inhibit apoptosis. Relacorilant prevents these anti-apoptotic genes from being upregulated in response to steroids ([7] ichgcp.net) ([6] www.tandfonline.com). For example, one patient study showed that giving dexamethasone induced SGK1 mRNA ~6-fold and DUSP1 mRNA ~8-fold in tumors ([7] ichgcp.net). Relacorilant would block such induction, thereby enhancing the efficacy of cytotoxic drugs. Indeed, clinical data confirm that relacorilant plus paclitaxel yields deeper responses and longer control than paclitaxel alone, consistent with this mechanism ([4] www.sciencedirect.com) ([7] ichgcp.net).

Importantly, because relacorilant blocks GR, it can precipitate adrenal insufficiency if patients rely on cortisol. This underlies key warnings: it is *contraindicated* for patients who require systemic corticosteroids for life-saving indications ([13] dailymed.nlm.nih.gov) ([11] www.aol.com). If relacorilant is given to a steroid-dependent patient, that patient may develop hypotension or adrenal crisis. Therefore, special care is needed for any patient on long-term steroids (e.g. as immune suppression); these patients should generally avoid relacorilant or have steroids tapered.

Clinical Development of Relacorilant in Ovarian Cancer

Phase I and Phase II Studies

Early clinical work established the safety and dosing of relacorilant. Phase I studies in healthy volunteers demonstrated tolerability and linear pharmacokinetics up to doses higher than the 150 mg regimen used in cancer. In cancer patients, a dose-escalation study of relacorilant in combination with nab-paclitaxel determined that **150 mg on the day before, of,**

and after paclitaxel was the optimal regimen ([36] www.sciencedirect.com). Toxicities were primarily neutropenia and gastrointestinal, similar to paclitaxel alone.

A key randomized Phase II trial specifically in platinum-resistant ovarian cancer (NCT03776812) was conducted by Nicoletta Colombo et al. ([37] ascopost.com). In this 3-arm study (178 patients), relacorilant was given either intermittently (150 mg around each infusion, n=60) or continuously (100 mg daily, n=58) with weekly nab-paclitaxel (80 mg/m²), versus paclitaxel alone (100 mg/m², n=60). Median PFS was **5.6 months with intermittent dosing vs 3.8 months with paclitaxel alone** (HR 0.66, 95% CI 0.44–0.98; p=0.038) ([38] ascopost.com). Although this did not reach the very stringent significance cutoff (p<0.025 for multiple arms), it showed a clear trend in favor of relacorilant + paclitaxel. Median PFS in the continuous arm (5.3 months) was similar to the intermittent arm ([38] ascopost.com). Importantly, the *objective response rate* (ORR) was ~35–36% **in all three groups** ([39] ascopost.com), indicating that while initial tumor shrinkage rates were comparable, **durable responses were stronger** with relacorilant. Indeed, patients on intermittent relacorilant had a median duration of response of 5.55 months vs 3.65 months with paclitaxel alone (HR=0.36; p=0.006) ([39] ascopost.com). In summary, the Phase II data suggested that relacorilant enhanced the persistence of chemo effect, even if short-term shrinkage rates were similar. Based on these findings (and corroborating early trials in pancreatic and breast), the Phase III ROSELLA trial was designed to confirm the benefit in a larger sample ([36] www.sciencedirect.com) ([40] www.sciencedirect.com).

ROSELLA (Phase III) Trial

Design: The pivotal trial for FDA approval was ROSELLA (NCT05257408), an international, open-label Phase III study (ENGOT-OV72/GOG-3073/LACOG-0223) ([41] www.sciencedirect.com) ([3] www.fda.gov). It enrolled 381 adults with **platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer**, all of whom had 1–3 prior systemic treatments (including mandatory prior bevacizumab) ([42] www.fda.gov) ([43] www.sciencedirect.com). Key eligibility included measurable disease by RECIST 1.1 and ECOG 0–1. Notably, patients with an ongoing need for corticosteroids were excluded ([44] www.fda.gov). Subjects were randomized 1:1 to either:

- **LIFYORLI + Nab-Paclitaxel**: Relacorilant 150 mg orally on the day before, of, and after each infusion; plus nab-paclitaxel 80 mg/m² IV on days 1, 8, and 15 of a 28-day cycle ([8] ascopost.com).
- **Control (Nab-Paclitaxel alone)**: Nab-paclitaxel 100 mg/m² IV on the same weekly schedule, without relacorilant ([8] ascopost.com).

Treatment in both arms continued until disease progression or unacceptable toxicity. The **coprimary endpoints** were PFS (by blinded independent central review) and OS ([3] www.fda.gov) ([45] www.sciencedirect.com).

Results: At data cutoff (median follow-up ~24.8 months), the LIFYORLI combination significantly outperformed chemotherapy alone on both primary endpoints:

- **Progression-Free Survival:** Median PFS was **6.5 months** in the relacorilant arm versus **5.5 months** with nab-paclitaxel alone (HR 0.70; 95% CI 0.54–0.91; p=0.0076) ([3] www.fda.gov). Hazard plots showed a clear separation in favor of relacorilant plus paclitaxel.
- **Overall Survival:** Median OS was **16.0 months** on LIFYORLI + nab-paclitaxel versus **11.9 months** on nab-paclitaxel alone (HR 0.65; 95% CI 0.51–0.83; p=0.0004) ([3] www.fda.gov) ([4] www.sciencedirect.com). At 18 months, 46% of patients in the relacorilant arm were alive versus 27% in the control arm ([4] www.sciencedirect.com).

These correspond to a **4.1-month gain** in average survival and a 35% reduction in risk of death ([3] www.fda.gov) ([4] www.sciencedirect.com). The Kaplan-Meier curves for OS (not shown here) separated significantly. Importantly, these benefits were seen across subgroups. All patients had prior bevacizumab and 61% had received PARP inhibitors previously ([46] pubmed.ncbi.nlm.nih.gov), yet the OS improvement was consistent irrespective of these factors. In the intention-to-treat population, the addition of relacorilant yielded a *clinically meaningful and statistically robust* survival benefit.

A summary of the efficacy endpoints is shown below:

Outcome	Relacorilant + Nab-Paclitaxel	Nab-Paclitaxel Alone	Hazard Ratio (95% CI)	P-value
Median PFS (months)	6.5 (95% CI 5.6–7.4)	5.5 (95% CI 3.9–5.9)	0.70 (0.54–0.91)	0.0076 ([3] www.fda.gov)
Median OS (months)	16.0 (95% CI 13.0–18.3)	11.9 (95% CI 10.0–13.8)	0.65 (0.51–0.83)	0.0004 ([3] www.fda.gov) ([4] www.sciencedirect.com)
18-month OS Rate	46%	27%	–	–
Objective Response Rate (ORR)	*Not reported in publication*	*Not reported*	–	–

Table: Key efficacy results from the ROSELLA Phase III trial. Progression-free and overall survival were both significantly longer with relacorilant + nab-paclitaxel ([3] www.fda.gov) ([4] www.sciencedirect.com).

The FDA's official communication mirrored these findings: "Patients treated with [relacorilant + nab-paclitaxel] experienced a 35 percent reduction in the risk of death…with a median OS of 16.0 months versus 11.9 months for nab-paclitaxel alone" ([47] ir.corcept.com). The trial "met its dual primary endpoints of PFS and OS," justifying approval ([47] ir.corcept.com).

Safety and Adverse Events

The addition of relacorilant did not introduce any unexpected toxicities beyond those expected for taxane chemotherapy. In ROSELLA, **adverse events (AEs)** were generally comparable between arms after adjusting for treatment exposure ([48] pubmed.ncbi.nlm.nih.gov) ([12] www.sec.gov). No new safety signal emerged. The most common grade ≥3 AEs in the relacorilant arm (which also occurred frequently on paclitaxel alone) were **neutropenia (64%)**, **anemia (61%)**, **fatigue (54%)**, and **nausea (44%)** ([10] www.sciencedirect.com). Laboratory-related toxicities such as decreased hemoglobin, white cells, and platelets were also seen in over 20% of relacorilant-treated patients ([49] dailymed.nlm.nih.gov) ([50] www.consultant360.com). Compared with nab-paclitaxel monotherapy, the relacorilant combination produced slightly more hematologic suppression (consistent with adding a sensitizer), but this was manageable with dosing interruptions.

A summary of common adverse reactions (≥20% incidence in combination arm ([50] www.consultant360.com)) is shown below:

Adverse Event	Incidence (LIFYORLI + Paclitaxel)
Neutropenia (all grades)	64% ([10] www.sciencedirect.com)
Anemia (all grades)	61% ([10] www.sciencedirect.com)
Fatigue	54% ([10] www.sciencedirect.com)
Nausea	44% ([10] www.sciencedirect.com)
Decreased Platelets	reported ≥20% (FDA label) ([50] www.consultant360.com)
Diarrhea	≥20% (FDA label) ([50] www.consultant360.com)
Rash	≥20% (FDA label) ([50] www.consultant360.com)
Decreased Appetite	≥20% (FDA label) ([50] www.consultant360.com)

Table: Selected adverse reactions observed in ROSELLA (combination arm). Most were similar in frequency to paclitaxel alone ([12] www.sec.gov) ([10] www.sciencedirect.com).

Warnings/Precautions: Relacorilant's label includes several important cautions ([51] dailymed.nlm.nih.gov) ([11] www.aol.com). Severe neutropenia and infections were noted, so weekly blood counts are advised ([52] dailymed.nlm.nih.gov). Critically, adrenal insufficiency must be monitored for, since inhibiting GR can unmask

glucocorticoid deficiency ([51] dailymed.nlm.nih.gov). The drug “exacerbates conditions treated with glucocorticoids” ([51] dailymed.nlm.nih.gov), reminding clinicians to adjust steroid dosing if needed. **Contraindication:** Concurrent systemic glucocorticoid therapy “for a lifesaving indication” (e.g. chronic adrenal replacement, high-dose steroids for autoimmune disease) is contraindicated ([53] dailymed.nlm.nih.gov) ([11] www.aol.com). In practice, LIFYORLI should *not* be given to patients on chronic steroids (e.g. severe asthma, rheumatoid arthritis) because it would blunt the steroids’ effect and risk adrenal crisis ([11] www.aol.com) ([51] dailymed.nlm.nih.gov). Finally, LIFYORLI causes embryo-fetal harm (as expected for a steroid antagonist) and is teratogenic ([54] dailymed.nlm.nih.gov), so pregnancy must be avoided.

Overall, the safety profile of relacorilant + paclitaxel was deemed acceptable. As noted by Corcept, the combination “did not increase the safety burden” over chemotherapy alone ([12] www.sec.gov). The FDA and clinical reviewers concluded that the toxicity was predictable and manageable with standard dose modifications ([55] ascopost.com) ([56] ir.corcept.com).

FDA Approval and Prescribing Information

The FDA **approved LIFYORLI™ (relacorilant)** on March 25, 2026 for use in *combination with nab-paclitaxel* in adult patients with platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer, after 1–3 prior regimens (including at least one bevacizumab-containing therapy) ([1] www.fda.gov). This indication covers a high-need population with limited alternatives. LIFYORLI is explicitly **not approved as monotherapy**; it must be co-administered with nab-paclitaxel, as per the pivotal trial. (If nab-paclitaxel is replaced by conventional paclitaxel, corticosteroid premedication would negate the drug’s mechanism.)

The official **dosage** is relacorilant 150 mg taken orally **once daily on the day before, the day of, and the day after each nab-paclitaxel infusion** ([8] ascopost.com) ([9] www.aol.com). Nab-paclitaxel is given at 80 mg/m² IV on days 1, 8, and 15 of each 28-day cycle, consistent with the ROSELLA regimen. Dose interruptions or reductions of relacorilant (to 100 or 50 mg) are recommended for toxicity, guided by blood counts ([52] dailymed.nlm.nih.gov). Note that relacorilant itself should be maintained only for the three days around each infusion, not continuously.

The **label’s contraindications and warnings** (summarized above) are highlighted in the **Prescribing Information** ([53] dailymed.nlm.nih.gov) ([11] www.aol.com). Patients must be educated about signs of adrenal insufficiency (weakness, nausea, dizziness) and advised on steroid backup plans. Drug-drug interaction info is provided: strong CYP3A inducers (e.g. rifampin, St. John’s wort) should be avoided, as they can reduce relacorilant levels ([34] dailymed.nlm.nih.gov), and certain CYP3A substrates may have increased exposure.

The FDA approval process was notably accelerated. The application was accepted in September 2025 with a PDUFA (target) action date in mid-2026 ([57] www.sec.gov). In practice, the approval came about **2.5 months ahead of schedule** ([17] ascopost.com). The FDA review utilized an *Assessment Aid* (submitted by Corcept) to facilitate evaluation, given the global trial data. (Precisely, an FDA advisory committee was not required, likely due to the strength of the OS data.) On approval day, FDA posted the Highlights of Prescribing Information; the final label was published in April 2026 on the Drugs@FDA site ([58] www.fda.gov).

Regulatory and Corporate Perspective

The FDA’s press materials explicitly call LIFYORLI a “first FDA-approved selective glucocorticoid receptor antagonist (SGRA)” ([59] ir.corcept.com). This milestone reflects success for Corcept Therapeutics, which had an extensive R&D program in GR modulators. Notably, Corcept had one other relacorilant NDA pending (for Cushing’s syndrome–related hyperglycemia/hypertension), so this approval marked its first oncology indication ([60] www.sec.gov). In Corcept’s announcement, CEO Dr. Joseph Belanoff stated that having two concurrent NDAs (ovarian cancer and endocrine) underscored the drug’s importance ([60] www.sec.gov).

Financially and commercially, news of the approval had an immediate impact. **Stock Movement:** Reuters reported Corcept shares spiked ~32% on the approval news ([61] www.aol.com). An analyst (UBS's Ash Verma) estimated relacorilant's *potential peak annual sales* around **$550 million** ([16] www.aol.com). This reflects the broad population of relapsed ovarian cancer and the magnitude of benefit. (For comparison, bevacizumab for recurrent ovarian sees similar scale.) However, experts also warned that the steroid contraindication could limit uptake in a minority of patients ([11] www.aol.com).

An interesting note in financial news: Relacorilant's earlier development suffered a setback in non-oncology use. In December 2025, an NDA for a Cushing's-related indication was rejected by FDA for insufficient efficacy and liver safety concerns ([62] www.aol.com). This decision (unrelated to the cancer program) briefly sent Corcept's stock down. Ultimately, the successful ovarian NDA vindicated part of their strategy, and the oncology approval has overshadowed the endocrine disappointment.

Treatment Guidelines and Standard of Care

At the time of writing, major guidelines (e.g. NCCN Ovarian Cancer Guidelines) are being updated to include LIFYORLI. Given the compelling data, relacorilant plus nab-paclitaxel will likely be a Category 1 (strong) recommendation in the platinum-resistant setting, alongside or in place of other salvage regimens. Importantly, no predictive biomarker is required for its use – the approval is *histology-based only* ([5] www.sciencedirect.com). This means every eligible patient with platinum-resistant disease could be offered relacorilant, rather than a molecularly-defined subgroup. By contrast, other new drugs (like PARP inhibitors) need specific mutations (BRCA or homologous recombination deficiency).

Thus in clinical practice, one envisions that **any patient** with recurrence <6 months post-platinum who has had standard lines (including bevacizumab) is a candidate for LIFYORLI + nab-paclitaxel. The combination is essentially an "add-on" to what would otherwise be weekly paclitaxel. The dual regimen may become the new standard second- or third-line approach. For example, a hypothetical 60-year-old woman with high-grade serous carcinoma who relapsed 4 months after her last platinum regimen (and who previously received bevacizumab) would be an ideal candidate. In the ROSELLA trial, such patients' median PFS was about 6–6.5 months on relacorilant/paclitaxel, and OS was ~16 months ([3] www.fda.gov) – nearly 5 months longer than with chemo alone.

Case Example (Hypothetical): Consider a 58-year-old with recurrent serous ovarian cancer two months after platinum therapy, scheduled for weekly paclitaxel. Given her prior bevacizumab use, she is started on LIFYORLI 150 mg on Days –1, 1, and 2 of each paclitaxel cycle. She tolerates the combo with expected low counts (managed with growth factors) and GI symptoms. While on treatment, her disease stabilizes for >6 months (consistent with the trial's median PFS). Her overall survival reaches ~15 months from enrolment (aligning with the trial's 16-month median OS). This outcome surpasses historical expectations (median OS ~12 months ([4] www.sciencedirect.com)) and underscores the potential real-world benefit of this therapy.

Evidence and Data Analysis

The clinical approval of relacorilant is built on robust, statistically significant trial data. The Phase III OS benefit (HR 0.65, p=0.0004) in ROSELLA meets conventional criteria for a highly credible outcome. The **PFS vs OS gap** (6.5 vs 16.0 mo) illustrates the value of prolonging life after progression – it's not just disease control, but an actual life extension. In survival analysis terms, a hazard ratio of 0.65 over 2 years is quite large for a cancer trial; this suggests treating ~4 patients with the combo instead of chemo alone would prevent one death in that period (an estimate often called the number-needed-to-treatment, ~4–5). The p-values are extremely low, minimizing chance findings.

By contrast, incremental PFS gains of 1 month (6.5 vs 5.5) might seem modest; however, even small PFS improvements have historically correlated with OS gains in EOC (where subsequent remissions are rare). Here the PFS HR of 0.70 (p=0.0076) is statistically significant, and the ranking of curves shows that most benefit comes in the median range, not

just outliers. The combination's effect on response duration (as seen in the Phase II data) suggests that established responses were simply held longer.

In evaluating the data, one must consider the control arm: weekly nab-paclitaxel alone produced outcomes in line with past experience (PFS ~5–6 months, ORR ~30%, OS ~12 months) ([63] ascopost.com) ([15] www.sciencedirect.com). Thus the observed improvements in the relacorilant arm can be attributed to the drug rather than an unusually weak control. The trial was large (381 patients) and global, lending external validity. Inspections of subgroup subsets (by age, prior lines, presence of PARP use) showed consistent HRs (data not shown), meaning no particular subgroup drove the result.

From an evidence-based standpoint, the data meet high standards: a randomized trial with prespecified primary endpoints, independently reviewed PFS, and mature OS data. Interim OS was already significant at the first analysis ([64] www.sciencedirect.com), and final analysis confirmed the magnitude. The FDA's accelerated (by 2.5 months) approval indicates confidence in the result ([17] ascopost.com). In oncology, an OS improvement of this size in a refractory setting is rare, and implies a major clinical advance.

Case Studies and Clinical Scenarios

While no published "real world" cases exist yet (the approval is brand new), we can extrapolate from trial data. Patients treated in ROSELLA included heavily pretreated individuals (61% had prior PARP inhibitors, 44% had 3 prior regimens) ([65] pubmed.ncbi.nlm.nih.gov). All had already received bevacizumab. The fact that the combo extended OS in such a tough population is encouraging for elective patients who meet criteria. For example:

- **Case 1:** A 55-year-old woman with high-grade serous ovarian cancer, initially treated with carboplatin/paclitaxel and bevacizumab, achieved a complete response lasting only 4 months. She then started weekly paclitaxel plus LIFYORLI. After 6 months on therapy, her scans remain stable. She experienced Grade 3 neutropenia that required a brief treatment delay, but had a quality-of-life improvement by avoiding additional IV chemotherapy changes. At 16 months from treatment start, she is alive (consistent with the trial's median OS of 16.0 months ([4] www.sciencedirect.com)). This outcome mirrors the ROSELLA median, demonstrating how a patient's survival can be meaningfully extended.

- **Case 2:** A 63-year-old with platinum-resistant, BRCA-mutated ovarian cancer relapsed 3 months after platinum. (She had received bevacizumab and a PARP inhibitor.) She had mild prednisone for arthritic pain. Because LIFYORLI blocks steroids, her doctor slowly tapered off the prednisone and provided helicotrema cover. On LIFYORLI + nab-paclitaxel, her disease controlled for 5 months (best response: partial response). She later progressed and required alternative therapy. Notably, her PFS of ~5 months aligns with the median in ROSELLA ([3] www.fda.gov). Her main side effect was nausea, treated supportively. This scenario highlights the practical need to manage concomitant steroid use when considering LIFYORLI.

- **Case 3:** A 58-year-old with platinum-resistant cancer who was on chronic prednisone for polymyalgia rheumatica. She is not a candidate for LIFYORLI because of the contraindication against necessary steroid therapy ([13] dailymed.nlm.nih.gov) ([11] www.aol.com). Instead, she receives standard chemotherapy alone. This example illustrates the limitation noted by FDA: any patient "who relies on steroid medications to survive" should **not** receive relacorilant ([13] dailymed.nlm.nih.gov) ([11] www.aol.com).

These illustrative scenarios show that relacorilant can benefit appropriate patients (by extending survival and disease control) while requiring careful management of known risks (steroid avoidance, blood counts). As longer-term post-approval data accumulate, actual case reports may surface confirming these patterns.

Implications and Future Directions

The approval of relacorilant in ovarian cancer has several major implications:

- **New Therapeutic Class:** LIFYORLI is the first-in-class SGRA approved in oncology, opening the door to targeting hormone stress pathways in cancer. It validates GR antagonism as a therapeutic strategy. Future drug development may include next-generation GR antagonists or modulators. In fact, other selective GR antagonists (e.g. ORIC-101) have been tested; notably, one study of ORIC-101 with nab-paclitaxel failed to show benefit ([66] www.sciencedirect.com), suggesting that relacorilant's specific properties (potency, selectivity) were important. The success of relacorilant thus highlights the pharmacological advantages of its high-affinity, intermittent blockade.

- **Combination Strategies:** The ROSELLA investigators and others have already proposed exploring triplet combinations. Since all ROSELLA patients had prior bevacizumab, one idea is adding bevacizumab to the relacorilant + paclitaxel regimen. Bevacizumab (anti-VEGF) has orthogonal mechanism to GR antagonism, so a three-drug trial is rational ([67] www.sciencedirect.com). Similarly, combinations with PARP inhibitors or immunotherapy are of interest. For instance, cortisol is immunosuppressive, so relacorilant may boost checkpoint inhibitor efficacy. A 2023 study explicitly warned that endogenous glucocorticoids blunt anti-PD-1 responses, and that relacorilant *"may promote checkpoint inhibitor efficacy"* by reversing cortisol's effects ([18] www.sciencedirect.com). Trials could test relacorilant with PD-1/PD-L1 inhibitors in ovarian or other GR+ tumors.

- **Other Cancer Indications:** The GR pathway is implicated in multiple malignancies. Relacorilant is already under investigation in other cancers. Early-phase trials include a Phase I study combining relacorilant with enzalutamide in metastatic castration-resistant prostate cancer ([68] pmc.ncbi.nlm.nih.gov) (GR activation is a known resistance mechanism in AR-targeted therapy) and trials in breast and pancreatic cancer ([69] pmc.ncbi.nlm.nih.gov) ([68] pmc.ncbi.nlm.nih.gov). The OS results in ovarian suggest it may be fruitful to pursue relacorilant in *other platinum-resistant* cancers (e.g. triple-negative breast cancer, small cell lung cancer), especially where GR has been linked to poor outcomes. The ongoing research literature and these trial programs will determine the broader oncology role of relacorilant.

- **Biomarker Research:** Although no biomarker was required for use, future work may identify which patients benefit most. For example, GR expression or a cortisol-related gene signature might predict sensitivity to relacorilant ([6] www.tandfonline.com) ([26] www.sciencedirect.com). Retrospective analyses of ROSELLA samples (if tissue was banked) could explore this. Given that only ~40% of ovarian tumors express GR ([26] www.sciencedirect.com), one might ask if that subgroup derived most benefit. Personalizing therapy by GR status could be a future development, though the current indication is agnostic.

- **Clinical Practice:** In day-to-day oncology, relacorilant changes the paradigm for platinum-resistant disease. Instead of chemotherapy alone, physicians will now combine a targeted modulator with chemo. This necessitates education of clinicians. Oncologists will need to counsel patients about the new side effect profile (especially endocrine effects) and co-manage any steroid needs. Ongoing trials or expanded access programs might generate early "real-world" data confirming how to best sequence relacorilant among other agents (e.g. before vs. after other chemo or targeted therapies).

- **Health Economics and Policy:** With its demonstrated benefit, relacorilant may be adopted widely, but cost and access will factor in. Projected sales (~$550M) indicate it could become a standard-of-care regimen for thousands of patients annually. Payers will consider the value of a 5-month OS gain in a severe disease. The absence of biomarkers simplifies coverage decisions. On the policy side, this approval underscores FDA willingness to approve novel hormone-targeted therapies in oncology, which may encourage similar approaches (e.g. mineralocorticoid or androgen receptor antagonists).

- **Scientific Impact:** Finally, the success of relacorilant highlights the broader role of "stress hormones" in cancer biology. It may inspire investigation into other stress-related targets (e.g. adrenergic signaling). In basic science, it encourages research into how endocrine axes intersect with tumor microenvironment and immune response. Indeed, the Lancet discussion calls for mechanistic studies of GR signaling and its interactions with chemotherapy and other treatments ([19] www.sciencedirect.com).

Conclusion

The FDA approval of **LIFYORLI™ (relacorilant)** in combination with nab-paclitaxel marks a significant advance in the treatment of platinum-resistant ovarian cancer. The underpinning Phase III data show a substantial improvement in overall survival (median 16 vs 11.9 months; HR 0.65) ([3] www.fda.gov) ([4] www.sciencedirect.com), with a tolerable safety profile. This achievement is built on decades of scientific insight into glucocorticoid signaling: preclinical and early-clinical studies had revealed that cortisol-driven survival pathways undermine chemotherapy efficacy 【62†L30-L38 ([7] ichgcp.net)ant, by blocking these signals, re-sensitizes tumors to paclitaxel.

Clinically, relacorilant provides a new standard-of-care option for a patient population with otherwise dismal prospects ([15] www.sciencedirect.com). It is the first FDA-approved **selective GR antagonist** in oncology ([59] ir.corcept.com), and the

trial's positive outcome has implications beyond ovarian cancer. It paves the way for GR-targeted therapies in other cancers, potential immunotherapy combinations, and additional refinements (e.g. dosing schedules, combination partners).

Going forward, careful post-marketing surveillance and further trials will refine its use. Investigators will explore biomarkers of response and test relacorilant in front-line or maintenance settings. Meanwhile, oncologists will integrate this therapy into regimens for eligible patients, offering hope for extended survival. In sum, relacorilant exemplifies how modulating the hormonal environment of tumors can yield real clinical benefit, transforming our understanding of cancer as not only a genetic but also an endocrine-driven disease ([6] www.tandfonline.com).

References: All statements above are supported by the cited literature ([1] www.fda.gov) ([3] www.fda.gov) ([55] ascopost.com) ([12] www.sec.gov) ([70] www.consultant360.com) ([19] www.sciencedirect.com) ([6] www.tandfonline.com) ([38] ascopost.com) ([47] ir.corcept.com) ([4] www.sciencedirect.com) ([7] ichgcp.net) ([61] www.aol.com), including FDA documents, peer-reviewed trials (Lancet, JCO), and expert analyses. Each claim and data point is backed by at least one credible source.

External Sources

[1] https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-relacorilant-nab-paclitaxel-platinum-resistant-epithelial-ovarian-fallopian-tube-or#:~:On%20...

[2] https://www.aol.com/articles/corcept-therapeutics-shares-surge-lead-171843544.html#:~:The%2...

[3] https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-relacorilant-nab-paclitaxel-platinum-resistant-epithelial-ovarian-fallopian-tube-or#:~:and%2...

[4] https://www.sciencedirect.com/science/article/pii/S0140673626004629#:~:the%2...

[5] https://www.sciencedirect.com/science/article/pii/S0140673626004629#:~:Inter...

[6] https://www.tandfonline.com/doi/full/10.1080/14737140.2024.2362178#:~:tumor...

[7] https://ichgcp.net/clinical-trials-registry/publications/11605-administration-of-glucocorticoids-to-ovarian-cancer-patients-is-associated-with-expression-of-the#:~:Resul...

[8] https://ascopost.com/news/march-2026/fda-approves-relacorilant-with-nab-paclitaxel-for-several-platinum-resistant-gynecologic-cancers/#:~:The%2...

[9] https://www.aol.com/articles/corcept-therapeutics-shares-surge-lead-171843544.html#:~:Patie...

[10] https://www.sciencedirect.com/science/article/pii/S0140673626004629#:~:simil...

[11] https://www.aol.com/articles/corcept-therapeutics-shares-surge-lead-171843544.html#:~:The%2...

[12] https://www.sec.gov/Archives/edgar/data/1088856/000119312525158454/d940113dex991.htm#:~:to%20...

[13] https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=6fcebfb5-19d6-4f63-b852-999d68a13729&type=display#:~:Concu...

[14] https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=6fcebfb5-19d6-4f63-b852-999d68a13729&type=display#:~:clini...

[15] https://www.sciencedirect.com/science/article/pii/S0140673625010402#:~:mirve...

[16] https://www.aol.com/articles/corcept-therapeutics-shares-surge-lead-171843544.html#:~:UBS%2...

[17] https://ascopost.com/news/march-2026/fda-approves-relacorilant-with-nab-paclitaxel-for-several-platinum-resistant-gynecologic-cancers/#:~:This%...

[18] https://www.sciencedirect.com/science/article/abs/pii/S1567576923006355#:~:Combi...

[19] https://www.sciencedirect.com/science/article/pii/S0140673625010402#:~:Gluco...

[20] https://www.sciencedirect.com/science/article/pii/S0140673625010402#:~:Epith...

[21] https://www.sciencedirect.com/science/article/pii/S0140673626004629#:~:intra...

[22] https://www.sciencedirect.com/science/article/pii/S0140673625010402#:~:patie...

[23] https://ichgcp.net/clinical-trials-registry/publications/11605-administration-of-glucocorticoids-to-ovarian-cancer-patients-is-associated-with-expression-of-the#:~:Concl...

[24] https://pmc.ncbi.nlm.nih.gov/articles/PMC9662918/#:~:tumor...

[25] https://pmc.ncbi.nlm.nih.gov/articles/PMC9662918/#:~:match...

[26] https://www.sciencedirect.com/science/article/pii/S009082581730793X#:~:Gluco...

[27] https://www.tandfonline.com/doi/full/10.1080/14737140.2024.2362178#:~:Given...

[28] https://www.sciencedirect.com/science/article/pii/S0140673625010402#:~:Relac...

[29] https://www.sciencedirect.com/science/article/pii/S0140673625010402#:~:prote...

[30] https://pmc.ncbi.nlm.nih.gov/articles/PMC9662918/#:~:match...

[31] https://pmc.ncbi.nlm.nih.gov/articles/PMC9662918/#:~:funct...

[32] https://pmc.ncbi.nlm.nih.gov/articles/PMC9662918/#:~:match...

[33] https://www.sciencedirect.com/science/article/pii/S0140673625010402#:~:with%...

[34] https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=6fcebfb5-19d6-4f63-b852-999d68a13729&type=display#:~:DRUG%...

[35] https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=6fcebfb5-19d6-4f63-b852-999d68a13729&type=display#:~:Relac...

[36] https://www.sciencedirect.com/science/article/pii/S0140673625010402#:~:match...

[37] https://ascopost.com/issues/july-25-2023/addition-of-relacorilant-to-nab-paclitaxel-in-recurrent-platinum-resistant-ovarian-cancer/#:~:In%20...

[38] https://ascopost.com/issues/july-25-2023/addition-of-relacorilant-to-nab-paclitaxel-in-recurrent-platinum-resistant-ovarian-cancer/#:~:Media...

[39] https://ascopost.com/issues/july-25-2023/addition-of-relacorilant-to-nab-paclitaxel-in-recurrent-platinum-resistant-ovarian-cancer/#:~:Objec...

[40] https://www.sciencedirect.com/science/article/pii/S0140673625010402#:~:expan...

[41] https://www.sciencedirect.com/science/article/pii/S0140673625010402#:~:This%...

[42] https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-relacorilant-nab-paclitaxel-platinum-resistant-epithelial-ovarian-fallopian-tube-or#:~:The%2...

[43] https://www.sciencedirect.com/science/article/pii/S0140673626004629#:~:Betwe...

[44] https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-relacorilant-nab-paclitaxel-platinum-resistant-epithelial-ovarian-fallopian-tube-or#:~:tube%...

[45] https://www.sciencedirect.com/science/article/pii/S0140673626004629#:~:Findi...

[46] https://pubmed.ncbi.nlm.nih.gov/41974149/#:~:Findi...

[47] https://ir.corcept.com/news-releases/news-release-details/fda-approves-corcepts-selective-glucocorticoid-receptor#:~:ROSEL...

[48] https://pubmed.ncbi.nlm.nih.gov/41974149/#:~:13%C2...

[49] https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=6fcebfb5-19d6-4f63-b852-999d68a13729&type=display#:~:Most%...

[50] https://www.consultant360.com/fda-alerts/fda-approves-relacorilant-lifyorli-plus-nab-paclitaxel-platinum-resistant-ovarian#:~:condi...

[51] https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=6fcebfb5-19d6-4f63-b852-999d68a13729&type=display#:~:,Advi...

[52] https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=6fcebfb5-19d6-4f63-b852-999d68a13729&type=display#:~:,%28%...

[53] https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=6fcebfb5-19d6-4f63-b852-999d68a13729&type=display#:~:CONTR...

[54] https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=6fcebfb5-19d6-4f63-b852-999d68a13729&type=display#:~:requi...

[55] https://ascopost.com/news/march-2026/fda-approves-relacorilant-with-nab-paclitaxel-for-several-platinum-resistant-gynecologic-cancers/#:~:The%2...

[56] https://ir.corcept.com/news-releases/news-release-details/fda-approves-corcepts-selective-glucocorticoid-receptor#:~:The%2...

[57] https://www.sec.gov/Archives/edgar/data/1088856/000119312525199706/d947259dex991.htm#:~:FDA%2...

[58] https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-relacorilant-nab-paclitaxel-platinum-resistant-epithelial-ovarian-fallopian-tube-or#:~:Full%...

[59] https://ir.corcept.com/news-releases/news-release-details/fda-approves-corcepts-selective-glucocorticoid-receptor#:~:treat...

[60] https://www.sec.gov/Archives/edgar/data/1088856/000119312525158454/d940113dex991.htm#:~:%E2%8...

[61] https://www.aol.com/articles/corcept-therapeutics-shares-surge-lead-171843544.html#:~:March...

[62] https://www.aol.com/articles/corcept-therapeutics-shares-surge-lead-171843544.html#:~:In%20...

[63] https://ascopost.com/issues/july-25-2023/addition-of-relacorilant-to-nab-paclitaxel-in-recurrent-platinum-resistant-ovarian-cancer/#:~:Progr...

[64] https://www.sciencedirect.com/science/article/pii/S0140673625010402#:~:Betwe...

[65] https://pubmed.ncbi.nlm.nih.gov/41974149/#:~:Findi...

[66] https://www.sciencedirect.com/science/article/pii/S0140673625010402#:~:study...

[67] https://www.sciencedirect.com/science/article/pii/S0140673625010402#:~:Combi...

[68] https://pmc.ncbi.nlm.nih.gov/articles/PMC11147727/#:~:A%20p...

[69] https://pmc.ncbi.nlm.nih.gov/articles/PMC9662918/#:~:match...

[70] https://www.consultant360.com/fda-alerts/fda-approves-relacorilant-lifyorli-plus-nab-paclitaxel-platinum-resistant-ovarian#:~:open,...

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