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New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization Drug Approval Form
Crenessity™ (crinecerfont)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. Is the patient 4 years of age and older? ☐ Yes ☐ No
2. Does the patient have a diagnosis of classic congenital adrenal hyperplasia due to 21-hydroxylase deficiency? **If yes, identify how diagnosis was confirmed. (Select all that apply.)** ☐ Yes ☐ No
   - ☐ Positive infant screening with secondary tier 2 confirmatory testing
   - ☐ Elevated serum 17-hydroxyprogesterone level (17OHP) above upper limit of normal
   - ☐ Cosyntropin (adrenocorticotropic hormone [ACTH] stimulation test
   - ☐ Genetic testing for mutation in the CYP21A2 gene consistent with CAH
3. Does the patient have hypersensitivity to Crenessity™ or any excipients of the product? ☐ Yes ☐ No
4. Is the patient currently receiving glucocorticoid replacement therapy? ☐ Yes ☐ No
5. Will the patient continue glucocorticoid treatment at a dosage required for replacement therapy? ☐ Yes ☐ No

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PATIENT LAST NAME:

PATIENT FIRST NAME:

6. Is the prescriber an endocrinologist or geneticist, or has the prescriber consulted with a specialist in congenital adrenal hyperplasia? ☐ Yes ☐ No

7. Is there any additional information that would help in the decision-making process?
   If additional space is needed, please use a separate sheet.

SECTION IV: RENEWAL

1. Has the patient had clinical benefit with the use of Crenessity™? ☐ Yes ☐ No

2. Has the patient experienced any treatment-restricting adverse effects? ☐ Yes ☐ No

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____