



New Hampshire AIDS Drug Assistance Program
Prior Authorization Drug Approval Form
Crenessity™ (crinelerfont)

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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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:** _____