



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

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: ☐ Male ☐ Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PHONE NUMBER:

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FAX NUMBER:

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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? ☐ Yes ☐ No
If yes, identify how diagnosis was confirmed. (Select all that apply.)
 - ☐ Positive infant screening with secondary tier 2 confirmatory testing
 - ☐ Elevated serum 17-hydroxyprogesterone level (17OHP) above upper limit of normal
 - ☐ Cosyntropin (adrenocorticotrophic 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

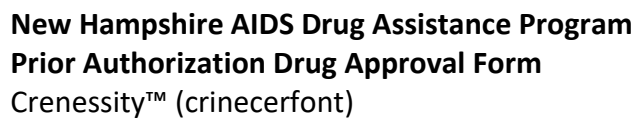
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- ## SECTION IV: RENEWAL

- 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:** _____