PRIOR AUTHORIZATION REQUEST

Crenessity

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		

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2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Will the patient continue to receive concomitant glucocorticoid replacement (e.g., dexamethasone, hydrocortisone, methylprednisolone, prednisone, prednisolone)? [If no, no further questions.]	Yes	No
6	Has the patient been taking the requested medication for AT LEAST 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of responses to requested medication include reduced androstenedione levels, decreased 17-hydroxyprogesterone levels, or reduction in glucocorticoid dose from baseline (e.g., prior to Crenessity therapy) or improved or stabilized clinical signs/symptoms of classic Congenital Adrenal Hyperplasia (e.g., decrease in body mass index standard deviation scores, improved insulin resistance, reduction of hirsutism, or improvement in androstenedione-to-testosterone ratio).] [No further questions.]	Yes	No
7	What is the indication or diagnosis? [] Classic congenital adrenal hyperplasia (CAH) (If checked, go to 8) [] Other (If checked, no further questions)		
8	Is the patient 4 years of age or older? [If no, no further questions.]	Yes	No

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9	Has documentation been submitted to confirm the patient has classic congenital adrenal hyperplasia (CAH) as evidenced by: A) Positive newborn screening with confirmatory second-tier testing, B) Pretreatment serum 17-hydroxyprogesterone (17-OHP) level greater than 3,000 ng/dL, C) Cosyntropin stimulation 17-OHP level greater than 10,000 ng/dL, or D) Genetic variant in *CYP21A2* gene? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Has the patient been taking systemic glucocorticoids (e.g., dexamethasone, hydrocortisone, methylprednisolone, prednisone, prednisolone)? ACTION REQUIRED: Submit supporting documentation. [Note: Total glucocorticoid doses in hydrocortisone dose equivalents - patients 4 to17 years of age require greater than 12 mg/m2/day or patients 18 years of age or older require greater than 13 mg/m2/day.] [If no, no further questions.]	Yes	No
11	Does the provider attest that the patient will continue to be treated with glucocorticoids in combination with the requested medication? [If no, no further questions.]	Yes	No
12	Does the patient have a history of bilateral adrenalectomy, hypopituitarism, or other conditions requiring chronic therapy with oral glucocorticoids? [If yes, no further questions.]	Yes	No
13	Does the patient have any evidence of chronic renal or liver disease? [If yes, no further questions.]	Yes	No
14	Does the patient have a history of clinically concerning cardiac arrhythmia (including long QT syndrome or prolongation of QT interval)? [If yes, no further questions.]	Yes	No
15	Is the requested medication prescribed by or in consultation with an endocrinologist and/or geneticist? [If no, no further questions.]	Yes	No
16	Does the prescribed dosing exceed Food and Drug Administration (FDA) approved indication? [Dosing weight: 10 kg to less than 20 kg: 25 mg twice daily. Dosing weight: 20 kg	Yes	No

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	to less than 55 kg: 50 mg twice daily. Dosing weight: greater than or equal to 55 kg: 100 mg twice daily.]		

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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