



Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Crenessity (crinecerfont)** for **Commercial, Exchange, FEHB (Federal), and MD Medicaid** plans. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: [Pharmacy | Community Provider Portal | Kaiser Permanente](#)

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____ Provider Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?

☐ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone # _____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Is this medication being prescribed by an Endocrinologist or Pediatric Endocrinologist?
☐ No ☐ Yes
2. Is the patient ≥ 4 years of age?
☐ No ☐ Yes
3. Does the patient have a diagnosis of 21-hydroxylase deficiency CAH (classic congenital adrenal hyperplasia) confirmed by at least ONE of the following?
 - ☐ Elevated 17-hydroxyprogesterone level
 - ☐ Confirmed CYP21A2 gene mutation
 - ☐ Positive newborn screening with confirmatory second-tier testing (e.g., serum testing for 17-hydroxyprogesterone and cortisol levels; serum electrolytes)
 - ☐ Cosyntropin (ACTH) stimulation test☐ No ☐ Yes
4. Is the patient currently taking a systemic glucocorticoid (e.g., hydrocortisone, prednisone, prednisolone, dexamethasone), AND will continue glucocorticoid therapy in combination with Crenessity?
☐ No ☐ Yes

For continuation of therapy, please respond to additional questions below. New members who were initiated on therapy outside of Kaiser, who have not been reviewed previously, must meet all above Clinical Criteria.

1. Does the patient continue to be under the care of an Endocrinologist or Pediatric Endocrinologist, and has had follow-up since last review?
☐ No ☐ Yes
2. Is there documentation of clinical benefit from therapy, as evidenced by disease stability or improvement (e.g., decreased androstenedione or 17-hydroxyprogesterone levels; reduction in required glucocorticoid dose from baseline; decrease in body mass index standard deviation scores; improved insulin resistance; reduction in hirsutism; improvement in androstenedione-to-testosterone ratio)
☐ No ☐ Yes

6 – Provider Sign-Off**Additional Information –**

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	Date:
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