SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: select one drug below

❑ **Crenessity®** (crinecerfont) **tablets**	❑ **Crenessity®** (crinecerfont) **oral solution**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosage:

- Adults: 100 mg orally twice daily
- Children ≥ 4 years and adolescents
  - 10 kg to less than 20 kg: 25 mg orally twice daily
  - 20 kg to less than 55 kg: 50 mg orally twice daily
  - ≥ 55 kg: 100 mg orally twice daily

Quantity Limits:

- 25, 50 & 100 mg capsule – maximum of 2 capsules per day
- 50 mg/mL solution: maximum of 120 mL per 30 days

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ❑ Medication must be prescribed by or in consultation with an endocrinologist, geneticist, or other physician who specializes in the treatment of congenital adrenal hyperplasia
- ❑ Member has a confirmed diagnosis of 21-hydroxylase deficiency congenital adrenal hyperplasia (CAH) **(submit documentation of cosyntropin stimulation 17OHP level > 10,000 ng/dL or genetic test results confirming genetic variant in CYP21A2 gene)**
- ❑ Medication will be taken in combination with a systemic glucocorticoid (i.e., hydrocortisone, prednisone, prednisolone, dexamethasone) and **ONE** of the following must be confirmed **(verified by chart notes and/or pharmacy paid claims)**:
  - ❑ Member is 4 to 17 years old and daily glucocorticoid dose is greater than 12 mg/m^2/day in hydrocortisone dose equivalents
  - ❑ Member is 18 years of age or older and daily glucocorticoid dose is greater than 13 mg/m^2/day in hydrocortisone dose equivalents
- ❑ Member has been receiving a stable regimen of a glucocorticoid for at least 30 days **(verified by chart notes and/or pharmacy paid claims)**
- ❑ Member's androstenedione and 17-hydroxyprogesterone levels are elevated despite compliance with maximally tolerated glucocorticoid therapy **(submit current lab test results)**
- ❑ **For liquid formulation requests in patients weighing ≥ 55 kg or patients weighing ≥ 20 kg with CYP3A4 dose adjustment requirement:** Documentation must be provided to confirm the member is unable to swallow capsules **(submit documentation of intolerance to capsules)**
- ❑ **For adult patients requesting doses above quantity limit of 200 mg daily:** Documentation of use of a moderate or strong CYP3A4 inducer must be submitted for approval

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Provider attests to an absence of unacceptable toxicity from the drug (i.e., hypersensitivity reactions, recurrent adrenal insufficiency or adrenal crisis events; etc.)
- ❑ Medication will continue to be taken in combination with a systemic glucocorticoid (i.e., hydrocortisone, prednisone, prednisolone, dexamethasone) **(verified by chart notes and/or pharmacy paid claims)**

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- ❑ Member has experienced positive disease response indicated by at least **ONE** of the following **(check all that apply; results must be submitted to document improvement)**:
  - ❑ Decreased androstenedione levels
  - ❑ Decreased 17-hydroxyprogesterone levels
  - ❑ Reduction in glucocorticoid dose from baseline while maintaining androstenedione levels and 17-hydroxyprogesterone levels that have been reduced or stabilized from baseline levels

Medication being provided by Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee**: ~~3/27/2025;~~ **5/22/2025**
REVISED/UPDATED/REFORMATTED~~: 4/16/2025;~~ **6/09/2025**