BlueCross BlueShield
Federal Employee Program

CRENESSITY
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)				Provider Information (required)			
Date:				Provider Name:			
Patient Name:				Specialty:		NPI:	
Date of Birth:		Sex: ❑Male ❑Female		Office Phone:		Office Fax:	
Street Address:				Office Street Address:			
City:		State:	Zip:	City:		State:	Zip:
Patient ID: **R**				Physician Signature:			
PHYSICIAN COMPLETES							

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Crenessity
(crinecerfont)

NOTE: Form must be completed in its **entirety** for processing

1. Does the patient have a diagnosis of classic congenital adrenal hyperplasia (CAH)? ❑Yes ❑No*
   If NO, please specify.: _____

2. Has the patient been on this medication continuously for the last 6 months excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions.
   a. Has the diagnosis been confirmed by a genetic test confirming the presence of pathogenic variants in CYP21A2?
   ❑Yes ❑No*

   If NO, has the diagnosis been confirmed by lab tests confirming 21-hydroxylase deficiency (e.g., baseline morning serum 17-hydroxyprogesterone (17-OHP) measurement by liquid chromatography-tandem mass spectrometry (LC-MS/MS), cosyntropin (ACTH) stimulation test, adrenal steroid profile)? ❑Yes ❑No

   b. Has the patient been stable on glucocorticoid therapy for at least 1 month? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question.
   a. Has the patient achieved or maintained a positive clinical response to therapy (e.g., reduction in glucocorticoid therapy)?
   ❑Yes ❑No

3. Will the patient continue glucocorticoid replacement therapy for adrenal insufficiency associated with CAH? ❑Yes ❑No

4. Will the patient need more than 400 milligrams per day? ❑Yes* ❑No
   If YES, please specify the requested milligrams per day: _____ mg per day