

**AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM**  
**DUR MEDICATION CRENESSITY™ (crinecerfont)**  
**Fax back to: 1-855-799-2553**

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

**MEMBER INFORMATION**

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Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Medicaid ID Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

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Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

NPI Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**DRUG INFORMATION**

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Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

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**DIAGNOSIS AND MEDICAL INFORMATION**

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**CRENESSITY™ – to receive a one (1) year approval for this drug, complete the following questions.**

1. Is the member 4 years of age or older?

Yes     No

2. Is the prescriber a specialist in the area of the member's diagnosis (e.g., endocrinologist, geneticist), or has the prescriber consulted with a specialist in the area of the member's diagnosis?

Yes     No

3. Does the member have a diagnosis of classic congenital adrenal hyperplasia (CAH) due to 21-hydroxylase deficiency as confirmed by ONE of the following:

- Positive infant screening with secondary tier 2 confirmatory testing; **OR**
- Elevated serum 17-hydroxyprogesterone level (17OHP) above the upper limit of normal (ULN); **OR**
- Cosyntropin (adrenocorticotrophic hormone [ACTH]) stimulation test; **OR**
- Genetic testing for mutation in the CYP21A2 gene consistent with CAH?

Yes     No

4. Is the member currently being treated with glucocorticoid replacement therapy (e.g., hydrocortisone, prednisone, prednisolone, dexamethasone)?

Yes     No

*(Form continued on next page.)*

**Member's Last Name:**

**Member's First Name:**

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**For renewal, complete the following questions to receive a 1-year approval:**

5. Does the member continue to meet the above criteria (questions 1 through 4)?

Yes       No

6. Does the member continue to experience clinical benefit from the requested treatment?

Yes       No

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**Prescriber Signature (Required)**

**Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; incomplete forms will delay the PA process.**

Submission of documentation does NOT guarantee coverage.