PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

2/20/2026

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Crenessity - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Crenessity - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Crenessity (crinecerfont)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Will the requested medication be used for any indications that are not Food and Drug Administration (FDA)-approved or guideline-supported? Y N

[If yes, no further questions.]

2.	Does the patient have severe renal impairment or end-stage renal disease?	Y N	
	[If yes, no further questions.]		
3.	Is the patient less than 4 years of age?	Y N	
	[If yes, no further questions.]		
4.	Has the plan authorized the requested medication in the past for this patient (i.e., previous authorization is on file under this plan)?	Y N	
	NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.		
	[If no, skip to question 6.]		
5.	Does the patient have documentation showing a positive response to treatment, evidenced by at least ONE of the following: A) Reduction in glucocorticoid usage, B) Decrease in body mass index standard deviation, C) Improved insulin resistance, or D) Reduction in hirsutism?	Y N	
	NOTE: Submission of medical records is required.		
	[No further questions.]		
6.	Does the patient have a diagnosis of classis congenital adrenal hyperplasia (CAH)?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
7.	Is there documentation of a genetic test confirmation of pathogenic variants in CYP21A2 gene?	Y N	
	NOTE: Submission of medical records is required.		
	[If yes, skip to question 9.]		
8.	Is there documentation of laboratory tests confirming 21-hydroxylase deficiency (such as baseline morning serum 17-hydroxyprogesterone (17-OHP), measured by liquid chromatography-tandem mass Spectrometry (LC-MS/MS), cosyntropin (ACTH) stimulation test, or adrenal steroid profile)?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
9.	Will the patient continue to receive concurrent treatment with glucocorticoids, and has been stable for at least one month?	Y N	
	NOTE: Submission of medical records is required.		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is

available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date