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Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
Finerenone (Kerendia)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for finerenone (Kerendia). Payment will be considered under the following conditions:

1) **Request adheres to all FDA approved labeling for indication, including age, dosing, contraindications, warnings and precautions, and drug interactions; and**
2) **Patient has a diagnosis of chronic kidney disease (CKD) associated with Type 2 Diabetes (T2D); and**
   a. **Patient is currently receiving a maximally tolerated dose of an angiotensin converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB); and**
   b. **Patient is currently receiving a maximally tolerated dose of a sodium-glucose co-transporter 2 (SGLT2) inhibitor indicated to reduce the risk of sustained eGFR decline, end-stage kidney disease, cardiovascular death, and hospitalization for heart failure in adults with chronic kidney disease (i.e., dapagliflozin [Farxiga], empagliflozin [Jardiance]); or**
3) **Patient has a diagnosis of heart failure; and**
   a. **Patient has a left ventricular ejection fraction (LVEF) ≥ 40%; and**
   b. **Patient is currently receiving a maximally tolerated dose of a SGLT2 inhibitor indicated for use in patients with heart failure (i.e., dapagliflozin [Farxiga], empagliflozin [Jardiance]); and**
4) **Patient has the following baseline tests prior to initiation of treatment with finerenone:**
   a. **Serum potassium is ≤ 5.0 mEq/L; and**
   b. **Estimated glomerular filtration rate (eGFR) is ≥ 25 mL/min/1.73m^2; and**
   c. **Urine albumin to creatinine ration (UACR) is ≥30 mg/g.**

The required trials may be overridden when documented evidence if provided that the use of these agents would be medically contraindicated.

Initial authorizations will be approved for one year. Additional PAs will be considered with the following documentation:

1. **Patient's eGFR is ≥ 25 mL/min/1.73m2; and**
2. **For a diagnosis of CKD associated with T2D:**
   a. **Patient's serum potassium is < 5.5 mEq/L; and**
   b. **Patient remains on a maximally tolerated dose of an ACEi or ARB; and**
   c. **Patient remains on a maximally tolerated dose of an SGLT2 inhibitor; or**

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3. **For a diagnosis of heart failure:**
   a. **Patient's serum potassium is < 6 mEq/L; and**
   b. **Patient remains on a maximally tolerated dose of an SGLT2 inhibitor.**

470-5716 (06/26)

Non-Preferred

☐ Kerendia

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Baseline tests prior to initiation of treatment (attach results):

- Serum Potassium ≤ 5.0 mEq/L ❑ Yes ❑ No
- eGFR ≥ 25mL/min/1.73m^2 ❑ Yes ❑ No
- UACR ≥ 30mg/g ❑ Yes ❑ No

❑ **CKD associated with T2D**

Document current treatment of a maximally tolerated dose of an ACEi or ARB:

Drug Name & Dose: _____ Start date: _____

Document current treatment of a maximally tolerated dose of a SGLT2 inhibitor indicated to reduce the risk of sustained eGFR decline, end-stage kidney disease, cardiovascular death, and hospitalization for heart failure in adults with chronic kidney disease:

Drug Name & Dose: _____ Start date: _____

❑ **Heart failure**

Does patient have a LVEF ≥ 40%? ❑ Yes ❑ No

Document current treatment of a maximally tolerated dose of a SGLT2 inhibitor indicated for use in patients with heart failure:

Drug Name & Dose: __Start date: ____

Renewal Requests

- eGFR ≥ 25mL/min/1.73m^2 ❑ Yes ❑ No

❑ **CKD associated with T2D**

- Serum Potassium < 5.5 mEq/L ❑ Yes ❑ No

Patient remains on a maximally tolerated dose of ACEi or ARB:

❑ Yes Drug Name & Dose: _____

❑ No

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Patient remains on a maximally tolerated dose of a SGLT2 inhibitor:
❑ Yes Drug Name & Dose: _____
❑ No

❑ **Heart failure**
- Serum potassium < 6 mEq/L

Patient remains on a maximally tolerated dose of SGLT2 inhibitor:
❑ Yes Drug Name & Dose: _____
❑ No

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*