Iowa Department of Human Services

Request for Prior Authorization
Finerenone (Kerendia)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(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**
3) **Patient is currently receiving a maximally tolerated dose of an angiotensin converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB); and**
4) **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)]; and**
5) **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 six months. Additional PAs will be considered with the following documentation:

1. **Patient's serum potassium is < 5.5 mEq/L; and**
2. **Patient's eGFR is ≥ 25 mL/min/1.73m2; and**
3. **Patient remains on a maximally tolerated dose of an ACEi or ARB; and**
4. **Patient remains on a maximally tolerated dose of an SGLT2 inhibitor.**

Non-Preferred

☐ Kerendia

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Request for Prior Authorization-*Continued*
Finerenone (Kerendia)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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: _____

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

<u>Renewal Requests</u>

Updated tests (attach results)

- Serum Potassium < 5.5 mEq/L ❑ Yes ❑ No
- eGFR ≥ 25mL/min/1.73m^2 ❑ Yes ❑ No

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

❑ Yes Drug Name & Dose: _____

❑ No

Patient remains on 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:

❑ 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.*