Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Kerendia (finerenone) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Kerendia (finerenone).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Prescriber is a Nephrologist or Endocrinologist,
   □ No □ Yes

2. **AND** documented diagnosis of type 2 diabetes mellitus in patients at least 18 years of age,
   □ No □ Yes

3. **AND** documented diagnosis of CKD (defined as eGFR 25-74 mL/min/1.73 m^2 and/or urinary albumin-to-creatinine ratio of >300),
   □ No □ Yes

4. **AND** patient is on ACEI or ARB therapy, or if not prescribed, provider has documented rationale,
   □ No □ Yes

5. **AND** documented baseline eGFR and serum potassium ≤4.8 mEq/L within past 3 months,
   □ No □ Yes

6. **AND** documented adequate therapeutic trial (≥3 months) and failure, contraindication, or intolerance to Jardiance AND at least 1 anti-mineralocorticoid (i.e. spironolactone/eplerenone)
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Documented beneficial response to therapy (i.e. no documentation of initiation of dialysis, kidney transplant, or decrease in eGFR of 40% or greater),
   □ No □ Yes

2. **AND** patient continues to be under the care of a specialist
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**