## SENTARA COMMUNITY PLAN (MEDICAID)

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST\*

<u>Directions</u>: <u>The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request</u>. All other information may be filled in by office staff; <u>fax to 1-800-750-9692</u>. No additional phone calls will be necessary if all information <u>(including phone and fax #s)</u> on this form is correct. <u>If the information provided is not complete, correct, or legible, the authorization process can be delayed.</u>

Drug Requested: Kerendia® (finerenone)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.				
Member Name:				
Member Sentara #:	Date of Birth:			
Prescriber Name:				
Prescriber Signature:	Date:			
Office Contact Name:				
Phone Number:				
NPI #:				
DRUG INFORMATION: Authori	zation may be delayed if incomplete.			
Drug Name/Form/Strength:				
Dosing Schedule:	Length of Therapy:			
Diagnosis:	ICD Code, if applicable:			
Weight (if applicable):	Date weight obtained:			
Ouantity Limit: 30 tablets per 30 days				

## Kerendia® Initial Dosing Recommendations:

eGFR (mL/min/1.73m <sup>2</sup> )	Starting Dose
≥ 60	20 mg once daily
$\geq$ 25 to < 60	10 mg once daily
< 25	Not Recommended

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Dose Adjustment Based on Current Serum Potassium Concentration and Current Kerendia® Dose				
		10 mg once daily	20 mg once daily	
Current Serum Potassium (mEq/L)	<b>≤ 4.8</b>	Increase the dose to 20 mg once daily*	Maintain 20 mg once daily	
	> 4.8 – 5.5	Maintain 10 mg once daily	Maintain 20 mg once daily	
	> 5.5	Withhold Kerendia <sup>®</sup> . Consider restarting at 10 mg once daily when serum potassium ≤ 5.0 mEq/L	Withhold Kerendia®. Restart at 10 mg once daily when serum potassium ≤ 5.0 mEq/L	

<sup>\*</sup>If eGFR has decreased by more than 30% compared to previous measurement, maintain 10 mg dose.

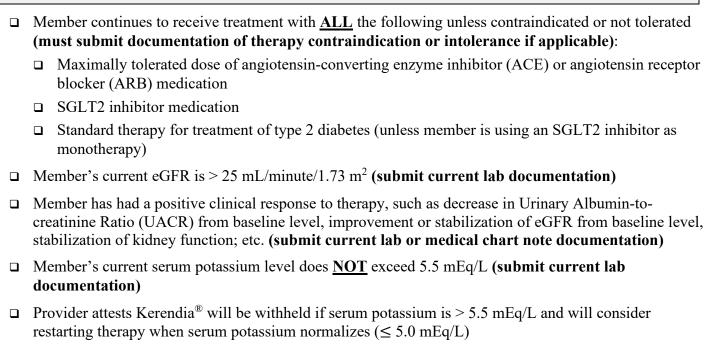
**CLINICAL CRITERIA:** Check below all that apply. <u>All criteria must be met for approval</u>. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

## **Initial Authorization: 6 months**

- ☐ Member is 18 years of age or older and has a diagnosis of chronic kidney disease associated with type 2 diabetes
- ☐ Must submit lab test results documenting **BOTH** of the following obtained within the past 60 days
  - $\square$  Members' current eGFR is > 25 mL/minute/1.73 m<sup>2</sup>
  - $\square$  Member's current Urinary Albumin-to -Creatinine Ratio (UACR) is  $\ge 30 \text{ mg/g}$
- □ Member's current serum potassium is  $\leq$ 5 mEq/L along with <u>BOTH</u> of the following (submit current lab documentation obtained within the past 60 days):
  - $\Box$  Therapy will <u>NOT</u> be initiated if serum potassium >5 mEq/L
  - $\Box$  Initiation with increased serum potassium monitoring during the first 4 weeks will be performed if serum potassium is > 4.8 to 5 mEq/L
- ☐ Member is established on treatment with maximally tolerated dose of angiotensin-converting enzyme inhibitor (ACE) or angiotensin receptor blocker (ARB) medication and will continue to take along with Kerendia<sup>®</sup> (finerenone)
- ☐ Member is established on standard therapy for treatment of type 2 diabetes
- ☐ Member is established on treatment with, or has a contradiction, or intolerance to, at least <u>ONE</u> sodium glucose transport protein 2 (SGLT2) inhibitor that is indicated for use in patients with chronic kidney disease (e.g., Farxiga<sup>®</sup>, Jardiance<sup>®</sup>)
- ☐ Member doses <u>NOT</u> have a diagnosis of adrenal insufficiency or a diagnosis of know significant non-diabetic renal disease, including clinically relevant renal artery stenosis
- ☐ Member is <u>NOT</u> receiving simultaneous treatment with strong CYP3A4 inhibitors
- □ For initial therapy, members will be dosed as follows:
  - $\Box$  eGFR  $\geq$  60 mL/minute/1.73 m<sup>2</sup>: starting dose will be 20 mg once daily
  - □ eGFR  $\geq$  25 to < 60 mL/minute/1.73 m<sup>2</sup>: starting dose will be 10 mg once daily

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**Reauthorization:** 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.



\*\*Use of samples to initiate therapy does not meet step edit/ preauthorization criteria. \*\*

\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes. \*