Montana Healthcare Programs Prior Authorization Request Form
for Use of Kerendia™ (finerenone)

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>DOB:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Member ID:</td>
<td>Prescriber Phone:</td>
<td></td>
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<tr>
<td>Prescriber Name/Specialty if applicable:</td>
<td>Prescriber Fax:</td>
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<td>Dosage Requested:</td>
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Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

1. Member is ≥ 18 years of age: □ Yes □ No
2. Medication is prescribed by or in consultation with a nephrologist: □ Yes □ No

   Action Required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

   Name of Specialist: _______________________________  Contact Date: ______________

3. Member is not pregnant: □ Yes □ No
4. Member has a diagnosis of Chronic Kidney Disease associated with Type II diabetes AND an A1C less than 8%: □ Yes □ No  A1C result: ___________  Date: ______________
5. Member has undergone a recent trial (within the past 90 days) of an SGLT2 with the same indication: □ Yes □ No  Drug name: ____________________________  Date: __________________

   If No, please provide the reason: ____________________________

7. Prior to the initiation of Kerendia®, member must meet all of the following:
   a) eGFR is ≥ 25ml/min/1.73m2 and <75ml/min/1.73m2: □ Yes □ No

   Action Required: Please provide the member’s two most recent eGFR levels:

   - eGFR result: ___________  Date: ______________
   - eGFR result: ___________  Date: ______________

   b) Urine albumin-to-creatinine ratio is ≥ 30mg/g: □ Yes □ No
   c) Serum potassium level is ≤ 5.0mEq/L: □ Yes □ No

LIMITATIONS:
Maximum dose is 1 tablet daily.

Initial authorization will be issued for 6 months.
CONTINUATION OF THERAPY

1. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A - Prescriber is specialist

2. Provider has attached documentation showing a positive clinical improvement (e.g., eGFR decline has been slowed): ☐ Yes ☐ No  Most recent eGFR result: ______________________ Date: __________

Reauthorization will be issued for 12 months.

Please complete form, including required attachments, and fax to Drug Prior Authorization Unit at 1-800-294-1350.