Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

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

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

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: _____**
6. Member is currently receiving a maximally tolerated ACE or ARB, unless contraindicated**:** ☐ **Yes** ☐ **No**

   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.

09/2021