Kerendia (finerenone)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Type II Diabetes(T2D) ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
Is the drug going to be used in conjunction with a clinical trial? ☐ Yes ☐ No
Does patient have a diagnosis of chronic kidney disease(CKD) ? ☐ Yes ☐ No

Does patient have persistent high albuminuria(UACR ≥30 to <300mg/g) ? ☐ Yes ☐ No *Please submit chart documentation.*

Does patient have an estimated glomerular filtration rate(eGFR) ≥25 but < 60mL/min/1.73m^2 (CKD EPI)? *Please submit chart documentation.*

Does patient have presence of diabetic retinopathy? ☐ Yes ☐ No *Please submit chart documentation.*

Does patient have persistent high albuminuria(UACR ≥300mg/g ? ☐ Yes ☐ No *Please submit chart documentation.*

Does patient have an estimated glomerular filtration rate(eGFR) ≥25 but < 75mL/min/1.73m^2 (CKD EPI)? ☐ Yes ☐ No *Please submit chart documentation.*

Has patient been treated with the maximally tolerated dose of an ACE or an ARB at least 4 weeks or more prior to starting Kerendia(finerenone)? ☐ Yes ☐ No *Please submit chart documentation.*
Does patient have known non-diabetic renal disease? ☐ Yes ☐ No
Does patient have renal stenosis? ☐ Yes ☐ No
Does patient have a mean sitting systolic blood pressure(SBP) ≥160mmHg? ☐ Yes ☐ No
Does patient have a mean sitting diastolic blood pressure(DBP) ≥100mmHg? ☐ Yes ☐ No
Does patient have a mean SBP <90mmHg? ☐ Yes ☐ No

Does patient have a HbA1c >12%? ☐ Yes ☐ No

Does patient have a clinical diagnosis of heart failure with reduced ejection fracture(EF) ≤40% ? ☐ Yes ☐ No *Please submit chart documentation.*

Does patient have NYHA class II-IV? ☐ Yes ☐ No

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Has patient had a stroke, transient ischemic attack, acute coronary syndrome, or hospitalization for worsening heart failure in the last 30 days prior to starting treatment with Kerendia(finerenone)? □ Yes □ No

Has patient had dialysis for acute renal failure within 12 weeks of starting Kerendia(finerenone)? □ Yes □ No

Has patient had a renal allograft in place or scheduled withing the next 12 months of starting Kerendia(finerenone)? □ Yes □ No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

***Please note:** Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Last Updated: 08/01/2022