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:**
☐ Heart Failure ☐ 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 Type II diabetes? ☐ 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)? ☐ Yes ☐ No *Please submit chart documentation.*

Does patient have presence of diabetic retinopathy? ☐ Yes ☐ No

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.*

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

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

Does patient have a diagnosis of heart failure with left ventricular ejection fraction (LVEF) ≥ 40% within the last 12 months? □ Yes □ No

Has the patient been on diuretic treatment for at least 30 days prior to starting Kerendia(finerenone)? □ Yes □ No *Please submit chart documentation.*
Does patient have a structural heart abnormality(s) based on any local imaging measurement within the last 12 months, defined by at least one of the following findings? □ Yes □ No *Please submit chart documentation.*

□ left atrial diameter (LAD) ≥3.8cm

□ left atrial area (LAA) ≥20cm2

□ left atrial volume index (LAVI) >30 mL/m2

□ left ventricular mass index (LVMI) ≥115 g/m2 (♂)/ 95 g/m2 (♀)

□ septal thickness or posterior wall thickness ≥1.1 cm

Does patient have an n-terminal prohormone B-type natriuretic peptide (NT-proBNP) ≥300 pg/mL or BNP ≥100 pg/mL in sinus rhythm? □ Yes □ No *Please submit chart documentation.*

Does patient have an ongoing diagnosis of paroxysmal atrial fibrillation or NT-proBNP ≥900 pg/mL or BNP ≥300 pg/mL in atrial fibrillation (or if atrial fibrillation status is unknown or if patient has an ongoing diagnosis of paroxysmal atrial fibrillation? □ Yes □ No *Please submit chart documentation.*
Has patient been screened ineligible for probable alternative causes of patient's HF symptoms that accounts for patient's dyspnea such as significant pulmonary disease, anemia or obesity? □ Yes □ No *Please submit chart documentation.*
Does patient have severe pulmonary disease requiring home oxygen, chronic oral steroid therapy, history of primary pulmonary arterial hypertension, valvular heart disease considered to be clinically significant, and/or a Body Mass Index (BMI) >50 kg/m2? □ Yes □ No *Please submit chart documentation.*

Does patient have systolic blood pressure(SBP) ≥160 mmHg, if not on treatment with ≥3 blood pressure lowering medications or ≥180 mmHg irrespective of treatments? □ Yes □ No *Please submit chart documentation.*

Has patient been treated with spironolactone for at least 30 days? □ Yes □ No *Please submit chart documentation.*

Does patient have an absolute contraindication to spironolactone or had a significant intolerance to spironolactone that is causing patient to stop therapy? □ Yes □ No *Please submit chart documentation.*

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If patient has an absolute contraindication to spironolactone or has had a significant intolerance to spironolactone that is causing patient to stop therapy, has patient been treated with eplerenone? □ Yes □ No *Please submit chart documentation.*
Does patient have an absolute contraindication to eplerenone or has had a significant intolerance to eplerenone that is causing patient to stop therapy? □ Yes □ No *Please submit chart documentation.*

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

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