Effective Date: 01/01/2022
Reviewed: 10/2021, 9/2022 Scope: Medicaid

Kerendia (finerenone)

POLICY

I. CRITERIA FOR APPROVAL

An authorization of 12 months may be granted when all the following criteria are met:

A. Patient is 18 years or older; AND
B. Patient has documented diagnosis of type 2 diabetes; AND
C. Member has chronic kidney disease (CKD) based on one of the following:
    a. Estimated glomerular filtration rate (eGFR) is 60 mL/min/1.73m2 or less for at least 3 months; OR
    b. Persistent moderate to severe albuminuria (urine albumin-to-creatinine ratio [UACR] 30 mg/g or greater, or 0.113 mg/mmol or greater) for at least 3 months; AND
D. Documentation that patient is currently receiving a maximally tolerated dose of an Angiotensin Converting Enzyme inhibitor (ACEI, e.g., lisinopril) or an Angiotensin Receptor Blocker (ARB, e.g., losartan) has been tried, unless all agents in these classes are contraindicated; AND
E. Documentation of treatment with one Sodium Glucose Co-transporter-2 (SGLT2) inhibitor (e.g., Farxiga, Invokana) has been ineffective, not tolerated, or all are contraindicated; AND
F. Kerendia will not be used in combination with a SGLT2 inhibitor (e.g., Jardiance, Invokana, Farxiga); AND
G. Patient has baseline eGFR rate of ≥ 25ml/min/1.73 m^2

II. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for all members when the following criteria are met:

A. Patients meets all initial criteria; AND
B. Patient has exhibited improvement or stability of disease symptoms (e.g., stabilization of eGFR, lack of hospitalization due to renal or cardiovascular disease); OR in the absence of improvement or stability of disease symptoms, the provider attests that continuation of therapy is medically necessary AND clinical rationale of medical necessity has been provided.

III. QUANTITY LIMIT

Kerendia 10mg or 20mg: one tablet per day

IV. COVERAGE DURATION

- 12 months