

Effective Date: 01/01/2022
Reviewed: 10/2021, 9/2022, 5/2023, 6/2024, 12/2024
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. The medication is prescribed by, or in consultation with, a cardiologist, endocrinologist, or nephrologist; AND
- C. Patient has documented diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes; AND
- D. Member meets all of the following at baseline:
  - a. Estimated glomerular filtration rate (eGFR) is  $\geq 25$  mL/min/1.73m<sup>2</sup>; AND
  - b. Urine albumin-to-creatinine ratio [UACR] is  $\geq 30$  mg/g; AND
  - c. Serum potassium level  $\leq 5.0$  mEq/L
- E. Documentation that patient is currently receiving a maximally tolerated and stabilized dose of an Angiotensin Converting Enzyme inhibitor (ACEi, e.g., lisinopril) or an Angiotensin Receptor Blocker (ARB, e.g., losartan), unless all agents in these classes are contraindicated; AND
- F. Documentation that patient is currently receiving a maximally tolerated dose of a sodium-glucose co-transporter 2 (SGLT2) inhibitor with renal benefit (e.g., dapagliflozin [Farxiga]) or has experienced a documented intolerance or contraindication that would prohibit a trial of a SGLT2 inhibitor with renal benefit (e.g., dapagliflozin [Farxiga])

#### 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

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## V. REFERENCES

1. Kerendia [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; September 2022.
2. Chronic Kidney Disease and Risk Management: Standards of Medical Care in Diabetes – 2023. *Diabetes Care*. Dec 2022;46:S191-S202.
3. KDIGO 2022 Clinical Practice Guideline for Diabetes Management in Chronic Kidney Disease. *Kidney International*. 2022;102(Suppl 5S):S1-S127.