HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM
KERENDIA® FOR HEALTHY U

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 888-509-8142.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance at 855-856-5694

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Kerendia® (finerenone)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a confirmed diagnosis of chronic kidney disease with moderate (30-300mg/g) albuminuria and a history of diabetic retinopathy?	☐	☐	**Please provide documentation**
2. Does the member have a confirmed diagnosis of chronic kidney disease with severe (300-5000mg/g) albuminuria?	☐	☐	**Please provide documentation**
3. Does the member have a confirmed diagnosis of Type 2 Diabetes Mellitus?	☐	☐	**Please provide documentation**
4. Does documentation show that the member has tried and failed, or has a contraindication/intolerance to, both of the following: • Angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) at maximally tolerated FDA-labeled dose • Farxiga® (dapagliflozin)	☐	☐	**Please provide documentation**
5. Do recent laboratory results show serum potassium level less than 4.8mEq/L prior to Kerendia® initiation?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member show a continued need for therapy?	☐	☐	**Please provide documentation**
3. Does documentation show the therapy is effective and tolerable?	☐	☐	**Please provide documentation**

4. Has continued monitoring of potassium levels been performed?	☐	☐	

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****