US Family Health Plan
Prior Authorization Request Form for finerenone (**Kerendia**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to Question **2**	☐ No **STOP** **Coverage not approved**
2. Is Kerendia prescribed by or in consultation with a nephrologist?	☐ Yes Proceed to Question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have type 2 diabetes? Note: Non-FDA approved used are NOT approved including not approved for use in renal transplant patients.	☐ Yes Proceed to Question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have diabetic kidney disease with albuminuria?	☐ Yes Proceed to Question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have an estimated glomerular filtration rate (eGFR) 25-75 with albuminuria greater than 300 mg/g?	☐ Yes Proceed to Question **7**	☐ No Proceed to Question **6**
6. Does the patient have eGFR 25-60 with albuminuria greater than 30 mg/g PLUS diabetic retinopathy?	☐ Yes Proceed to Question **7**	☐ No **STOP** **Coverage not approved**
7. Is the patient on max-dose ACE inhibitor or ARB for more than four weeks?	☐ Yes Proceed to Question **8**	☐ No **STOP** **Coverage not approved**

8. Has the patient tried DoD's preferred SGLT2 inhibitor empagliflozin (Jardiance)?	☐ Yes Proceed to Question **9**	☐ No **STOP** **Coverage not approved**
9. Is the patient on appropriate background therapy for diabetes and chronic kidney disease?	☐ Yes Proceed to Question **10**	☐ No **STOP** **Coverage not approved**
10. Does the patient have uncontrolled hypertension (greater than 170/110 mmHg) at initiation?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to Question **11**
11. Is the patient concomitantly taking CYP3A4 inhibitors (for example, phenytoin, phenobarbital, rifampicin) or inducers (for example, diltiazem, verapamil, ketoconazole, itraconazole, ritonavir)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to Question **12**
12. Does the patient have renal artery stenosis?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to Question **13**
13. What is the patient's gender?	☐ Male **Sign and date below**	☐ Female Proceed to Question **14**
14. Is the patient of childbearing potential?	☐ Yes Proceed to Question **15**	☐ No **Sign and date below**
15. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to Question **16**
16. Has the patient been counseled for two forms of contraception?	☐ Yes Proceed to Question **17**	☐ No **STOP** **Coverage not approved**
17. Does the patient have a negative pregnancy test?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date.

Prescriber Signature _____ Date _____