Pharmacy Medical Necessity Guidelines:
Kerendia (finerenone)

Effective: May 1, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617-673-0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

Kerendia is indicated to reduce the risk of:

- Sustained eGFR decline, end-stage kidney disease, cardiovascular death, non-fatal myocardial infarction, and hospitalization for heart failure in adult patients with chronic kidney disease (CKD) associated with type 2 diabetes
- Cardiovascular death, hospitalization for heart failure, and urgent heart failure visits in adult patients with heart failure with left ventricular ejection fraction (LVEF) greater than or equal to 40 percent.

COVERAGE GUIDELINES

The plan may authorize coverage of **Kerendia** for Members when the following criteria are met:

Chronic Kidney Disease associated with Type 2 Diabetes

1. The member is 18 years of age or older

AND

2. The member has a documented diagnosis of type 2 Diabetes

AND

3. The member has a documented diagnosis of chronic kidney disease

AND

4. The member is currently taking, or has had a trial and failure with or contraindication or intolerance to at least one medication in the following classes:
   i. Angiotensin-converting enzyme inhibitor (ACEi)

   OR

   ii. Angiotensin II receptor blocker (ARB)

AND

5. The member has had a trial and failure with, or contraindication or intolerance to a sodium-glucose cotransporter 2 (SGLT2) inhibitor (e.g., Farxiga, Jardiance)

Heart Failure

1. The member is 18 years of age or older

AND

2. The member has a documented diagnosis of heart failure with left ventricular ejection fraction (LVEF) of 40 percent or greater

AND

3. The member is currently taking, or has had a trial and failure with or contraindication or intolerance to at least one medication in the following classes:
   i. Angiotensin-converting enzyme inhibitor (ACEi)

   OR

   ii. Angiotensin II receptor blocker (ARB)

   OR

   iii. Angiotensin receptor/neprilysin inhibitor (ARNI) (e.g., sacubitril/valsartan)

AND

4. The member has had a trial and failure with, or contraindication or intolerance to a sodium-glucose cotransporter 2 (SGLT2) inhibitor (e.g., dapagliflozin, empagliflozin)

AND

5. The member has had a trial and failure with, or contraindication or intolerance to BOTH of the following mineralocorticoid receptor antagonists: spironolactone, eplerenone

LIMITATIONS

1. The following quantity limitations apply:

Kerendia	30 tablets per 30 days

CODES

None

REFERENCES

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APPROVAL HISTORY

September 13, 2022: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. July 11, 2023: No changes.
2. April 9, 2024: Effective May 1, 2024, updated RxUM fax number.
3. April 8, 2025: No changes
4. April 14, 2026: Effective May 1, 2026, added coverage criteria for heart failure based on expanded indication in adult patients with heart failure with LVEF ≥ 40%.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based

on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Provider Services