# Avance

Clinical Policy Title:	finerenone
Policy Number:	RxA.699
Drug(s) Applied:	Kerendia®
Original Policy Date:	08/18/2021
Last Review Date:	11/20/2023
Line of Business Policy Applies to:	All lines of business (except Medicare)

## Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria. The provision of provider samples does not guarantee coverage under the terms of the pharmacy benefit administered by RxAdvance. All criteria for initial approval must be met in order to obtain coverage.

#### Ι. **Initial Approval Criteria**

- A. CKD associated with Type 2 Diabetes (must meet all):
  - 1. Diagnosis of chronic kidney disease associated with type 2 diabetes;
  - 2. Prescribed by or in consultation with a nephrologist or an endocrinologist;
  - 3. Member meets all of the following (a, b, and c)
    - a. eGFR of  $\geq$ 25 mL/min/1.73 m<sup>2</sup>;
    - b. Urine albumin-to-creatinine ratio  $\geq$  30 mg/g;
    - c. Serum potassium ≤4.8 mEq/L
  - 4. Member is currently taking an ACE or ARB inhibitor at maximally tolerated doses for more than 30 days, unless contraindicated or clinically significant side effects are experienced;

## **Approval Duration**

All Lines of Business (except Medicare): 12 months

#### Π. **Continued Therapy Approval**

A. CKD associated with Type 2 Diabetes (must meet all):

Member is currently receiving medication, excluding manufacturer samples;

**Approval Duration** 

All Lines of Business (except Medicare): 12 months

## References

1. IPD Analytics RxInsights\_New Drug Review\_ Kerendia<sup>®</sup>\_08 2021. Available at: https://secure.ipdanalytics.com/User/Pharma/RxStrategy/Search?g=Kerendia. Accessed April 26, 2022.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	08/19/2021	09/14/2021
<ul><li>Policy was reviewed:</li><li>1. Dosing Information, Dosing Regimen, finerenone</li></ul>	04/26/2022	07/18/2022

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

© 2023 RxAdvance Corporation. All rights reserved. This policy contains the confidential and proprietary information of RxAdvance. Unauthorized reproduction, distribution, modification, display, storage, transmission, or use of this policy or any information contained herein is strictly prohibited. Revised 04/2022



(Kerendia<sup>®</sup>): Updated to include dosing information for eGFR (mL/min/1.73m<sup>2</sup>) < 25 for indication CKD associated with T2D.

- 2. Initial Approval Criteria, I.A.4:
  - a. updated to remove "or stage 2,3, or 4 CKD".
  - b. and updated to include:
     Urine albumin-to-creatinine ratio ≥ 30 mg/g.
- Initial Approval Criteria, I.A.5: Updated combination therapy criteria from Member is on concurrent therapy with an ACE inhibitor or ARB to Member is on concurrent therapy with an ACE inhibitor or ARB at maximally tolerated doses for ≥ 4 weeks, unless contraindicated or clinically significant side effects are experienced.
- Initial Approval Criteria, I.A.7: Updated to remove prior trial and failure criteria "Member has tried and failed both SGLT2 inhibitors: Farxiga, Invokana".
- Appendix B, Drug Name: Updated to include therapeutic alternatives:
  - a. captopril
  - b. enalapril (Vasotec<sup>®</sup>, Epaned<sup>®</sup>)
  - c. fosinopril
  - d. lisinopril (Zestril®, Qbrelis®)
  - e. perindopril
  - f. quinapril (Accupril<sup>®</sup>)
  - g. ramipril (Altace<sup>®</sup>)
  - h. trandolapril
  - i. candesartan (Atacand®)
  - j. losartan (Cozaar®)
  - k. telmisartan (Micardis<sup>®</sup>)
  - l. valsartan (Diovan<sup>®</sup>)
- 6. Disclaimer about

contraindications "Contraindications listed reflect statements made in the manufacturer's package insert..." was added to Appendix C.

© 2022 RxAdvance Corporation. All rights reserved. This policy contains the confidential and proprietary information of RxAdvance. Unauthorized reproduction, distribution, modification, display, storage, transmission, or use of this policy or any information contained herein is strictly prohibited.



<ol> <li>References were reviewed and updated.</li> </ol>		
Policy was reviewed.	11/20/2023	11/20/2023