PRIOR AUTHORIZATION REQUEST

Kerendia

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication?	Yes	No

If you have any questions, call: 1-888-258-8250

Version 09.2025

PRIOR AUTHORIZATION REQUEST

	[If no, skip to question 7.]		
3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [NOTE: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
8	Does the patient have a diagnosis of type 2 diabetes? [If no, no further questions.]	Yes	No
9	Have non-diabetic kidney disease processes been evaluated and ruled out? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Does the patient have chronic heart failure with reduced ejection fraction and persistent symptoms (New York Heart Association [NYHA] Class II - IV)? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
11	Has the patient required dialysis for acute renal failure within the last 90 days?	Yes	No

PRIOR AUTHORIZATION REQUEST

	ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]		
12	Has the patient experienced a stroke, transient ischemic attack (TIA), acute coronary syndrome or required hospitalization for worsening heart failure within the last 30 days? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
13	Does the patient have hepatic insufficiency classified as Child-Pugh Class C? [If yes, no further questions.]	Yes	No
14	Has the patient currently been receiving a maximally tolerated dose of a sodium-glucose co-transporter 2 (SGLT2) inhibitor for at least 3 months? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 16.]	Yes	No
15	Does the patient have a contraindication to the use of sodium-glucose co-transporter 2 (SGLT2) inhibitors? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Has the patient currently been receiving a maximally tolerated labeled dosage of an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) for 4 weeks or is there a documented contraindication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	Prior to initiation, does the patient have ALL of the following: A) Estimated glomerular filtration rate greater than or equal to 25 mL/min/1.73 m2, B) Urine albumin-to-creatinine ratio greater than or equal to 30 mg/g, C) Serum potassium level between 3.5 to 5.0 mEq/L? ACTION REQUIRED: Submit supporting documentation.	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

PRIOR AUTHORIZATION REQUEST

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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Version 09.2025