



## 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?		
	<input type="checkbox"/> Initial (If checked, go to 7)		
	<input type="checkbox"/> Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples of the requested medication?	Yes	No

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

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[If yes, skip to question 7.]

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|----|--|-----|----|
| 4  | Does the patient have a previously approved prior authorization (PA) on file with the current plan?<br>[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.]<br>[If no, skip to question 7.]   | Yes | No |
| 5  | Has the patient been established on therapy for at least 3 months?<br>[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.<br>[No further questions.]  | Yes | No |
| 7  | Is the patient greater than or equal to 18 years of age?<br>[If no, no further questions.]   | Yes | No |
| 8  | 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 m <sup>2</sup> , 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.<br>[If no, no further questions.]  | Yes | No |
| 9  | Does the patient have hepatic insufficiency classified as Child-Pugh Class C?<br>[If yes, no further questions.]   | Yes | No |
| 10 | Does the provider attest that the medication will not be used concurrently with strong CYP3A4 inhibitors (i.e., ketoconazole, protease inhibitors, clarithromycin)?<br>[If no, no further questions.]  | Yes | No |
| 11 | What is the diagnosis or indication?<br><br><input type="checkbox"/> Reduce risk of sustained estimated glomerular filtration rate (eGFR) decline, end-stage kidney disease, cardiovascular (CV) death, non-fatal myocardial infarction, and hospitalization for heart failure (HF) in adults with chronic kidney disease (CKD) associated with type 2 diabetes (If checked, go to 12)<br><br><input type="checkbox"/> Reduce risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visits in adults with heart failure with left ventricular ejection fraction (LVEF) greater than or equal to 40% (HFmrEF and HFpEF) (If checked, go to 19)<br><br><input type="checkbox"/> Other (If checked, no further questions) |     |    |
| 12 | Does the patient have a diagnosis of type 2 diabetes?<br>[If no, no further questions.]  | Yes | No |
| 13 | Have non-diabetic kidney disease processes been evaluated and ruled out? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.]   | Yes | No |

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14	Has the patient required dialysis for acute renal failure within the last 90 days? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
15	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 17.]	Yes	No
16	Does the patient have contraindication to the use of sodium-glucose co-transporter 2 (SGLT2) inhibitors? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	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
18	Is the medication prescribed by or in consultation with an endocrinologist, nephrologist, or clinician experienced in chronic kidney disease or type 2 diabetes management? [No further questions.]	Yes	No
19	Does the patient have chronic heart failure (New York Heart Association [NYHA] Class II-IV) with documented left ventricular ejection fraction (LVEF) greater than or equal to 40%? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Has the patient currently been receiving a maximally tolerated labeled dosage of a diuretic for at least 4 weeks prior to requesting Kerendia? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
21	Has the patient tried and failed a maximally tolerated labeled dosage of a mineralocorticoid receptor antagonist (i.e., spironolactone, eplerenone) for at least 3 months prior to requesting Kerendia? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
22	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 24.]	Yes	No
23	Does the patient have contraindication to the use of sodium-glucose co-transporter 2 (SGLT2) inhibitors? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
24	Does the provider attest to measure and monitor serum potassium and estimated glomerular filtration rate (eGFR) 4 weeks after initiating treatment and periodically throughout treatment to adjust the dose as needed? [If no, no further questions.]	Yes	No

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25	Does the provider attest that the medication will not be used concurrently with another mineralocorticoid receptor antagonist (i.e., spironolactone, eplerenone)? [If no, no further questions.]	Yes	No
26	Is the request prescribed by or in consultation with a cardiologist or heart failure specialist?	Yes	No

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

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### **SECTION B:** Physician Signature

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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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