

## **FINERENONE** SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta government sponsored drug programs.

Please complete all required sections to allow your request to be processed.

| PATIENT INFORMATION  |                                |   | COVERAGE TYPE  |            |           |                 |       |  |
|--|--------------------------------|---|--|------------|-----------|-----------------|-------|--|
| LAST NAME  | FIRST NAME                     |   |  | INITIAL    | _         | rta Blue Cross  |       |  |
| BIRTH DATE (YYYY-MM-DD)  | ALBERTA PERSONAL HEALTH NUMBER |   |  | <u> </u>   | │         |                 |       |  |
|  |                                |   |  |            | ☐ Other   |                 |       |  |
| ADDRESS  | CITY                           | PROV  | POSTAL CODE ID/CLIENT/CO   |            |           | IT/COVERAGE NUM | BER   |  |
| PRESCRIBER INFORMATION   |                                |   |  |            |           |                 |       |  |
| PRESCRIBER LAST NAME FIRST NAME INITIAL PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION   |                                |   |  |            |           |                 | ATION |  |
| PRESCRIBER LAST NAIVIE FIRST NAIVIE INTIAL   |                                |   | ☐ CPSA ☐ ACO REGISTRATION NUMBER   |            |           |                 |       |  |
| ADDRESS  |                                |   | ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other  |            |           |                 |       |  |
| CITY, PROVINCE   |                                |   | PHONE FAX  |            |           |                 |       |  |
| POSTAL CODE  | FAX I                          | FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED |  |            |           |                 |       |  |
| Criteria for Coverage of Finerenone (e.g., Kerendia)   |                                |   |  |            |           |                 |       |  |
| "Special authorization coverage may be provided as an adjunct to standard of care therapy to reduce the risk of end-stage kidney disease or cardiovascular death, fatal myocardial infarction or hospitalization for heart failure in adult patients with chronic kidney disease (CKD) and Type 2 diabetes (T2D), if the following criteria are met: |                                |   |  |            |           |                 |       |  |
| 1) Patients must have: - an estimated glomerular filtration rate (eGFR) level of at least 25 mL/min/1.73 m2, and - an albuminuria level of at least 30 mg/g (or 3 mg/mmol)   |                                |   |  |            |           |                 |       |  |
| 2) Patients must not have: - New York Heart Association [NYHA] class II to IV heart failure.   |                                |   |  |            |           |                 |       |  |
| Coverage cannot be provided for use in combination with another mineralocorticoid receptor antagonist (MRA).   |                                |   |  |            |           |                 |       |  |
| For coverage, this drug must be prescribed by a physician who has experience in the diagnosis and management of patients with CKD and T2D.   |                                |   |  |            |           |                 |       |  |
| Special authorization may be granted for 6 months.   |                                |   |  |            |           |                 |       |  |
| Note: Consider discontinuation of finerenone if the patient has an eGFR less than 15 mL/min/1.73 m2 or urinary albumin-to-creatinine ratio (UACR)  |                                |   |  |            |           |                 |       |  |
| increase from baseline level while receiving finerenone."  |                                |   |  |            |           |                 |       |  |
| The following product(s) are eligible for auto-renewal.  Please provide the following information for NEW requests   |                                |   |  |            |           |                 |       |  |
| Diagnosis, please check all that apply   |                                |   |  |            |           |                 |       |  |
| ☐ Chronic kidney disease ☐ Other, specify  |                                |   |  |            |           |                 |       |  |
| ☐ Type 2 diabetes  |                                |   |  |            |           |                 |       |  |
| Pre-treatment information, please answer 1-5 below   |                                |   |  |            |           |                 |       |  |
| 1) Is the requested drug intended for use as an adjunct to standard of care therapy?   |                                |   |  |            |           | ☐ Yes           | □No   |  |
| 2) Does the patient have an estimated glomerular filtration rate (eGFR) level of at least 25 mL/min/1.73 m2?   |                                |   |  |            |           | 2? ☐ Yes        | □No   |  |
| 3) Does the patient have an albuminuria level of at least 30 mg/g (or 3 mg/mmol)?  |                                |   |  |            | ☐ Yes     | □No             |       |  |
| 4) Will the requested drug be used in combination with another mineralocorticoid receptor antagonist (MRA)?  |                                |   |  |            | A)? ☐ Yes | □No             |       |  |
| 5) Does the patient have New York Heart Association [NYHA] class II to IV heart failure?   |                                |   |  |            | ☐ Yes     | □No             |       |  |
| Additional information related to request  |                                |   |  |            |           |                 |       |  |
|  | DATE (YYYY-MM-DD)              | Alberta E<br>10009 10<br>FAX <b>78</b> (                | ease forward this request to Alberta Blue Cross, Clinical Drug Services 10009 108 Street NW, Edmonton, Alberta T5J 3C5 FAX 780-498-8384 in Edmonton • 1-877-828-4106 toll free all other areas |            |           |                 |       |  |
| ONCE YOUR REQUEST HAS SUC  | CESSFULLY TRANSMIT             | TED. PLEA   | SE DO  | NOT MAIL O | R RE-FA   | X YOUR REQUEST. |       |  |

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

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