ALBERTA BLUE CROSS®

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	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other _____
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NUMBER
ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			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
☐ Type 2 diabetes
☐ Other, specify _____

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?	☐ 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)?	☐ 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

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please 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 SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.