PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

2/20/2026

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Kerendia - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Kerendia - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Kerendia (finerenone)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Will the requested medication be used for any indications that are not Food and Drug Administration (FDA)-approved or guideline-supported? Y N

[If yes, no further questions.]

2.	Does the patient have any of the following: A) Severe hepatic impairment (Child Pugh C), B) Adrenal insufficiency, C) Concurrently receiving treatment with strong CYP3A4 inhibitors, or D) Concurrently receiving treatment with other mineralocorticoid receptor antagonists, such as spironolactone or eplerenone?	Y N
	[If yes, no further questions.]	
3.	Is the patient less than 18 years of age?	Y N
	[If yes, no further questions.]	
4.	Has the plan authorized the requested medication in the past for this patient (i.e., previous authorization is on file under this plan)?	Y N
	NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
	[If no, skip to question 9.]	
5.	Does the patient have a diagnosis of heart failure (HF)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, skip to question 7.]	
6.	Is there documentation showing patient continues to tolerate therapy?	Y N
	NOTE: Submission of medical records is required.	
	[No further questions.]	
7.	Dose the patient have a diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
8.	Has the patient experienced a reduction in estimated glomerular filtration rate (eGFR) decline and disease progression?	Y N
	NOTE: Submission of medical records is required.	
	[No further questions.]	
9.	Does the patient have a documented diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, skip to question 14.]	
10.	Does the patient have persistent high albuminuria (Urine Albumin-to-Creatinine Ratio [UACR] 30 to 300 mg/g), estimated glomerular filtration rate (eGFR) 25 to 60 mL/min/1.73 square meters, and presence of diabetic retinopathy?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 12.]	

11. Does the patient have persistent very high albuminuria (UACR greater than or equal to 300 mg/g) and eGFR 25 to 75 mL/min/1.73 square meters?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
12. Does the patient have a serum potassium less than or equal to 4.8 mmol/L?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
13. Is the patient currently receiving a maximum tolerated dose of an angiotensin-converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB) unless their use is contraindicated?	Y N	
NOTE: Submission of medical records is required.		
[No further questions.]		
14. Does the patient have a documented diagnosis of heart failure with clinical symptoms (New York Heart Association [NYHA] class II, III, or IV)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
15. Does the patient have documentation showing the patient has a left ventricular ejection fraction (LVEF) greater than or equal to 40%?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
16. Does the patient have documented estimated glomerular filtration rate (eGFR) greater than or equal to 25 mL/min/1.73 square meters and serum potassium less than or equal to 5.0 mEq/L?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
17. Does the patient have documentation showing patient has had trial and intolerance to, or is currently receiving treatment with formulary dapagliflozin, unless the use of a sodium-glucose cotransporter 2 (SGLT-2) inhibitor therapy is contraindicated?	Y N	
NOTE: Submission of medical records is required.		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date