Clinical Policy: Finerenone (Kerendia)

Reference Number: CP.PMN.266
Effective Date: 12.01.21
Last Review Date: 11.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Finerenone (Kerendia®) is a non-steroidal mineralocorticoid receptor antagonist.

FDA Approved Indication(s)

Kerendia is indicated to reduce:

- The risk of sustained estimated glomerular filtration rate (eGFR) decline, end stage kidney disease, cardiovascular death, non-fatal myocardial infarction, and hospitalization for heart failure in adult patients with chronic kidney disease (CKD) associated with type 2 diabetes (T2DM)
- Urinary albumin-to-creatinine ratio (UACR), which is expected to reduce the risk of sustained eGFR decline and end-stage kidney disease in adults with CKD associated with type 1 diabetes mellitus (T1DM)
- The risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visits in adult patients with heart failure with left ventricular ejection fraction (LVEF) ≥ 40%

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Kerendia is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Kidney Disease (must meet all)**:**

1. Diagnosis of both of the following (a and b):
   a. CKD;
   b. T1DM or T2DM;
2. Age ≥ 18 years;
3. All of the following (a, b, and c):
   a. eGFR ≥ 25 mL/min/1.73 m^2;
   b. UACR is one of the following (i or ii):
      i. For CKD associated with T1DM: ≥ 200 mg/g;
      ii. For CKD associated with T2DM: ≥ 30 mg/g;
   c. Serum potassium ≤ 5.0 mEq/L;
4. For CKD associated with T2DM, one of the following (a or b):^
   a. Member is currently receiving a preferred sodium-glucose co-transporter 2 (SGLT2) inhibitor* (see *Appendix B* for examples);

b. Failure of ≥ 3 consecutive months of a preferred SGLT2 inhibitor*, unless contraindicated or clinically significant adverse effects are experienced;

^For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395

**Prior authorization may be required for SGLT2 inhibitors*

5. Member is currently receiving an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) at maximally tolerated doses for ≥ 4 weeks, unless clinically significant adverse effects are experienced or all are contraindicated;
6. Dose does not exceed both of the following (a and b):
   a. 20 mg per day;
   b. 1 tablet per day.

Approval duration: 12 months

B. Heart Failure (must meet all)**:**

1. Diagnosis of heart failure of New York Heart Association (NYHA) Class II, III, or IV;
2. Prescribed by or in consultation with a cardiologist;
3. Age ≥ 18 year;
4. Member has a LVEF ≥ 40% (i.e., heart failure with mildly reduced or preserved ejection fraction);
5. Both of the following (a and b):
   a. eGFR ≥ 25 mL/min/1.73 m^2;
   b. Serum potassium ≤ 5.0 mEq/L;
6. Failure of one other mineralocorticoid receptor antagonist (i.e., spironolactone, eplerenone), unless contraindicated or clinically significant adverse effects are experienced;*

   **For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395*
7. One of the following (a or b):
   a. Member is currently receiving a preferred SGLT2 inhibitor* (see *Appendix B* for examples);
   b. Failure of ≥ 3 consecutive months of a preferred SGLT2 inhibitor*, unless contraindicated or clinically significant adverse effects are experienced;

   **Prior authorization may be required for SGLT2 inhibitors*
8. Dose does not exceed both of the following (a and b):
   a. 40 mg per day;
   b. 1 tablet per day.

Approval duration: 12 months

C. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed both of the following (a and b):
   a. 1 tablet per day;
   b. One of the following (i or ii):
      i. For CKD: 20 mg per day;
      ii. For heart failure: 40 mg per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ACE: angiotensin converting enzyme
ARB: angiotensin receptor blocker
CKD: chronic kidney disease
eGFR: estimated glomerular filtration rate
FDA: Food and Drug Administration
NYHA: New York Heart Association
SGLT2: sodium-glucose co-transporter 2
T1DM: type 1 diabetes mellitus
T2DM: type 2 diabetes mellitus
UACR: urinary albumin-to-creatinine ratio

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
ACE Inhibitors		
captopril (Capoten®)	Doses vary	450 mg/day
enalapril (Vasotec®, Epaned®)		40 mg/day
fosinopril (Monopril®)		80 mg/day
lisinopril (Prinivil®, Zestril®, Qbrelis®)		80 mg/day
perindopril (Aceon®)		16 mg/day
quinapril (Accupril®)		80 mg/day
ramipril (Altace®)		20 mg/day
trandolapril (Mavik®)		8 mg/day
ARBs		
candesartan (Atacand®)	Doses vary	32 mg/day
losartan (Cozaar®)		100 mg/day
telmisartan (Micardis®)		80 mg/day
valsartan (Diovan®)		320 mg/day
SGLT2 Inhibitors		
dapagliflozin (Farxiga®)	Doses vary	10 mg/day
Jardiance® (empagliflozin)		25 mg/day
Mineralocorticoid Receptor Antagonists		
spironolactone (Aldactone®)	25-50 mg PO QD	50 mg/day
eplerenone (Inspra®)	50 mg PO QD	50 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): concomitant use with strong CYP3A4 inhibitors, adrenal insufficiency, hypersensitivity to any component of this product
- Boxed warning(s): none

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CKD associated with T1DM or T2DM	10 mg or 20 mg PO QD based on eGFR and serum potassium thresholds. Increase to target dose of 20 mg PO QD after 4 weeks based on eGFR and serum potassium thresholds.	20 mg/day
Heart failure	10 mg or 20 mg PO QD based on eGFR and serum potassium thresholds. Increase to target dose of 40 mg PO QD after 4 weeks based on eGFR and serum potassium thresholds.	40 mg/day

VI. Product Availability

Tablets: 10 mg, 20 mg, 40 mg

VII. References

1. Kerendia Prescribing Information. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; September 2026. Available at: https://www.kerendia-us.com/. Accessed September 22, 2026.
CKD
2. Bakris GL, Agarwal R, Anker SD, et al. Effect of finerenone on chronic kidney disease outcomes in type 2 diabetes. N Engl J Med. 2020 Dec;383(23):2219-2229.
3. Writing Committee Members, Ndumele CE, Rodriguez F, et al. 2026 AHA/ACC/ADA/ASN Guideline for the Prevention, Detection, Evaluation, and Management of Cardiovascular-Kidney-Metabolic Syndrome: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Circulation. 2026;154(4):e50-e158.
4. Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group. KDIGO 2024 clinical practice guideline for the evaluation and management of chronic kidney disease. Kidney Int. 2024;105(4S):S117-S314.
5. Kidney Disease: Improving Global Outcomes (KDIGO) Diabetes Work Group. KDIGO 2022 Clinical Practice Guideline for Diabetes Management in Chronic Kidney Disease. Kidney Int. 2022;102(5S):S1-S127.
6. de Boer IH, Khunti K, Sadusky T, et al. Diabetes management in chronic kidney disease: a consensus report by the American Diabetes Association (ADA) and Kidney Disease: Improving Global Outcomes (KDIGO). Kidney Int. 2022;102(5):974-989.
7. American Diabetes Association Professional Practice Committee. Standards of Care in Diabetes-2026. Diabetes Care. 2026;49(Suppl 1):S1-S371.
Heart failure
8. Solomon SD, McMurray JJV, Vaduganathan M, et al. Finerenone in heart failure with mildly reduced or preserved ejection fraction. N Engl J Med. (2024) 391(16):1475–85.

9. Heidenreich PA, Bozkurt B, Aguilar D, et al. 2022 AHA/ACC/HFSA guideline for the management of heart failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. J Am Coll Cardiol. 2022 May, 79 (17) e263–e421.
10. Kittleson MM, Panjrath GS, Amancherla K, et al. 2023 ACC Expert consensus decision pathway on management of heart failure with preserved ejection fraction: a report of the American College of Cardiology Solution Set Oversight Committee. J Am Coll Cardiol. 2023;81(18):1835-1878.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2022 annual review: added redirection to SGLT inhibitor per American Diabetes Association guideline; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section.	08.15.22	11.22
4Q 2023 annual review: no significant changes; references reviewed and updated.	08.11.23	11.23
4Q 2024 annual review: for initial criteria, removed upper eGFR limit of 75 mL/min/1.73 m^2 and added concurrent SGLT inhibitor use as an option to failure of an SGLT2 inhibitor per competitor analysis and guidelines; references reviewed and updated.	07.19.24	11.24
4Q 2025 annual review: RT4: added new heart failure indication and accompanying 40 mg dosage strength; for CKD, added criterion requiring serum potassium ≤ 5.0 mEq/L per PI; references reviewed and updated.	08.15.25	11.25
4Q 2026 annual review: no significant changes; added HIM IL bypass for CKD indication; added ICHRA line of business; references reviewed and updated. RT4: added new indication for CKD associated with T1DM.	09.22.26	11.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering

benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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