Kerendia (finerenone) Step Therapy with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date **Date of Origin**
12-01-2024

FDA LABELED INDICATIONS AND DOSAGE

Agent(s)	FDA Indication(s)	Notes	Ref#
Kerendia® (finerenone) Tablets	To reduce the risk of sustained 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 (T2D)		1

See package insert for FDA prescribing information: https://dailymed.nlm.nih.gov/dailymed/index.cfm

CLINICAL RATIONALE

Chronic Kidney Disease (CKD) and Diabetes	Chronic kidney disease (CKD) is diagnosed by blood and urine laboratory tests, which include screening for albuminuria and a low estimated glomerular filtration rate (eGFR). These tests are often paired with biopsies and imaging to determine the underlying cause of renal dysfunction. It is crucial to emphasize that CKD, commonly known as diabetic kidney disease when linked to diabetes, affects 20-40% of adults with diabetes. This association underscores the critical need for regular monitoring and early intervention in diabetic patients, as it can significantly reduce the risk of complications. Diabetic kidney disease is associated with increased morbidity and mortality, primarily due to poor cardiovascular outcomes and a progression to end-stage kidney disease.(2) The American Diabetes Association's (ADA) Standards of Medical Care in Diabetes-2024 recommends routine annual urinary albumin and eGFR screening for individuals with type 2 diabetes. More frequent screening is recommended for people with diabetic kidney disease, depending on the stage of kidney disease. Treatment of diabetic kidney disease focuses on the optimization of glucose control to prevent the progression of CKD. Additionally, an emphasis is placed on adequate blood pressure control to reduce adverse cardiovascular outcomes and slow the progression of CKD.(2,3) The International Society of Nephrology Kidney Disease Improving Global Outcomes (KDIGO) guidelines recommend that people who have both CKD and diabetes should utilize a broad-based treatment strategy that emphasizes improving cardiovascular and kidney outcomes.(4) Guidelines for the management of CKD in patients with type 2 diabetes recommend control of hypertension and hyperglycemia, as well as the use of a renin–angiotensin system (RAS) blocker (an angiotensin-converting–enzyme [ACE] inhibitor or angiotensin-receptor blocker [ARB]) and, more recently, a sodium–glucose cotransporter 2 (SGLT2) inhibitor.(2) Both the ADA and KDIGO guidelines recommend ACEIs or ARBs for slowing the progression of CKD in patients with diabetes, with the dose titrated to the highest approved dose that is tolerated.(2,3,4) Additionally, the KDIGO guidelines also state that glycemic management for patients with type 2 diabetes and CKD should include first-line treatment with metformin and a sodium-glucose cotransporter-2 (SGLT2) inhibitor, with further drug therapy as needed for glycemic control, (unless pretreatment eGFR less than 20 ml/min). SGLT2 inhibitors have a significant effect on reducing CKD progression that appears to be independent

	of eGFR. Even when glycemic targets are achieved on metformin, an SGLT2 inhibitor should be added for their beneficial effects. The KDIGO guidelines recommend that selecting an SGLT2 inhibitor should prioritize agents with documented kidney or cardiovascular benefits and consider eGFR.(4) Of these, canagliflozin, dapagliflozin, and empagliflozin have obtained FDA approval for reducing the risk of sustained eGFR decline, end-stage kidney disease, cardiovascular death, and hospitalization for heart failure in adults with CKD at risk of progression.(2,3) Nonetheless, despite recommended treatment, a risk of CKD progression remains. Evidence supports a pathophysiological role for the overactivation of the mineralocorticoid receptor in cardiorenal diseases, including CKD and diabetes, through inflammation and fibrosis that leads to progressive kidney and cardiovascular dysfunction.(2,4) In the 2024 edition of the American Diabetes Association's Standards of Medical Care in Diabetes, a recommendation was made for patients with type 2 diabetes and chronic kidney disease who are at increased risk for cardiovascular events or chronic kidney disease progression. In these patients, consideration should be given for the use of SGLT2 inhibitors; a glucagon-like peptide 1 agonist (GLP1) or a nonsteroidal mineralocorticoid receptor antagonist (finerenone) is recommended to reduce chronic kidney disease progression and cardiovascular events.(2,3) The (KDIGO) guidelines recommend a nonsteroidal mineralocorticoid receptor antagonist (finerenone) with proven kidney or cardiovascular benefit for patients with type 2 diabetes, an eGFR greater than or equal to 25 ml/min per 1.73 m^2, normal serum potassium concentration, and albuminuria (greater than or equal to 30 mg/g [greater than or equal to 3 mg/mmol]) despite maximum tolerated dose of a renin–angiotensin system (RAS) blocker.(4) These recommended treatments offer hope and optimism for the management of CKD in diabetic patients, potentially improving their quality of life and reducing the risk of complications. Finerenone is a nonsteroidal, selective antagonist of the mineralocorticoid receptor (MR), which is activated by aldosterone and cortisol and regulates gene transcription. Finerenone blocks MR-mediated sodium reabsorption and MR overactivation in both epithelial (e.g., kidney) and nonepithelial (e.g., heart and blood vessels) tissues. MR overactivation is thought to contribute to fibrosis and inflammation.(1)
Efficacy	The FIDELIO-DKD and FIGARO-DKD studies were randomized, double-blind, placebo-controlled, multicenter studies in adult patients with chronic kidney disease (CKD) associated with type 2 diabetes. Both trials excluded patients with known significant non-diabetic kidney disease. All patients were to have a serum potassium less than or equal to 4.8 mEq/L at screening and be receiving standard of care background therapy, including a maximum tolerated labeled dose of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker. Patients with a clinical diagnosis of chronic heart failure with reduced ejection fraction and persistent symptoms (New York Heart Association class II to IV) were excluded. The starting dose of Kerendia was based on screening eGFR. The dose of Kerendia could be titrated during the study, with a target dose of 20 mg daily. The FIDELIO-DKD patients were followed for 2.6 years and the FIGARO-DKD patients were followed for 3.4 years.(1) At baseline, 99.8% of patients were treated with an ACEi or ARB. Approximately 97% were on an antidiabetic agent (insulin [64.1%], biguanides [44%], glucagon-like peptide-1 [GLP-1] receptor agonists [7%], sodium-glucose cotransporter 2 [SGLT2] inhibitors [5%]), 74% were on a statin, and 57% were on an antiplatelet agent. In the FIGARO-DKD study, background therapies were similar to the FIDELIO-DKD study.(1) In the FIDELO-DKD trial, Kerendia reduced the incidence of the primary composite endpoint of a sustained decline in eGFR of greater than or equal to 40%, kidney failure, or renal death (HR 0.82, 95% CI 0.73-0.93, p=0.001). The treatment effect reflected a reduction in a sustained decline in eGFR of greater than or equal to 40% and progression to kidney failure. Kerendia also reduced the incidence of the composite endpoint of cardiovascular (CV) death, non-fatal myocardial infarction (MI), and non-fatal stroke or hospitalization for heart failure (HR 0.86, 95% CI 0.75-0.99, p=0.034). The treatment effect reflected a reduction in CV death, non-fatal MI, and hospitalization for heart failure. In the FIGARO-DKD study, Kerendia reduced the

	incidence of the primary composite endpoint of CV death, non-fatal MI, non- fatal stroke or hospitalization for heart failure (HR 0.87, 95% CI 0.76-0.98, p = 0.026). The treatment effect was mainly driven by an effect on hospitalization for heart failure, though CV death also contributed to the treatment effect.(1)
Safety	Kerendia is contraindicated in patients concomitantly using strong CYP3A4 inhibitors and in patients with adrenal insufficiency. Treatment with Kerendia should not be initiated if serum potassium is greater than 5 mEq/L. Initiation of treatment with Kerendia is not recommended if estimated glomerular filtration rate (eGFR) is less than 25 mL/min/1.73m^2.(1)

REFERENCES

Number	Reference
1	Kerendia prescribing information. Bayer HealthCare Pharmaceuticals Inc. September 2022.
2	ElSayed NA, Grazia Aleppo, Bannuru RR, et al. 11. Chronic Kidney Disease and Risk Management: *Standards of Care in Diabetes—2024*. *Diabetes Care*. 2023;47(Supplement_1):S219-S230. doi:https://doi.org/10.2337/dc24-s011
3	ElSayed NA, Grazia Aleppo, Bannuru RR, et al. 10. Cardiovascular Disease and Risk Management: *Standards of Care in Diabetes—2024*. *Diabetes Care*. 2023;47(Supplement_1):S179-S218. doi:https://doi.org/10.2337/dc24-s010
4	Stevens PE, Ahmed SB, Juan Jesus Carrero, et al. KDIGO 2024 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease. *Kidney International*. 2024;105(4):S117-S314. doi:https://doi.org/10.1016/j.kint.2023.10.018

POLICY AGENT SUMMARY STEP THERAPY

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Kerendia	finerenone tab	10 MG ; 20 MG	M ; N ; O ; Y	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Kerendia	Finerenone Tab	10 MG	30	Tablets	30	DAYS			
Kerendia	Finerenone Tab	20 MG	30	Tablets	30	DAYS			

CLIENT SUMMARY – STEP THERAPY

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Kerendia	finerenone tab	10 MG ; 20 MG	Commercial ; HIM ; ResultsRx

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Kerendia	Finerenone Tab	10 MG	Commercial ; HIM ; ResultsRx
Kerendia	Finerenone Tab	20 MG	Commercial ; HIM ; ResultsRx

STEP THERAPY CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval

Target Agent(s) will be approved when ONE of the following is met:

TARGET AGENT(S)	PREREQUISITE AGENT(S)
Kerendia (finerenone)	One from each group below: Group 1 • Product containing an ACE inhibitor • Product containing an ARB Group 2 • Product containing a DPP-4 • Product containing a GLP-1 • Product containing an insulin • Product containing metformin • Product containing a SGLT2

1. The requested agent is eligible for continuation of therapy AND ONE of the following:

Agents Eligible for Continuation of Therapy
All target agents are eligible for continuation of therapy

   A. The patient has been treated with the requested agent (starting on samples is not approvable) within the past 180 days **OR**
   B. The prescriber states the patient has been treated with the requested agent (starting on samples is not approvable) within the past 180 days AND is at risk if therapy is changed **OR**
2. BOTH of the following:
   A. ONE of the following:
      1. The patient has a medication history of use in the past 180 days, intolerance, or hypersensitivity to a product containing an ACE inhibitor or an ARB **OR**
      2. The patient has an FDA labeled contraindication to ALL products containing an ACE inhibitor or an ARB **AND**
   B. ONE of the following:
      1. The patient has a medication history of use in the past 180 days, intolerance, or hypersensitivity to a product containing a DPP-4, GLP-1, insulin, metformin, or SGLT2 **OR**
      2. The patient has an FDA labeled contraindication to ALL products containing a DPP-4, GLP-1, insulin, metformin, or SGLT2

Length of Approval: 12 months

NOTE: Quantity Limit applies, please refer to Quantity Limit Criteria.

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
Universal QL	**Quantity limit for the Target Agent(s)** will be approved when ONE of the following is met: 1. The requested quantity (dose) does NOT exceed the program quantity limit **OR** 2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: A. BOTH of the following: 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication **AND** 2. There is support for therapy with a higher dose for the requested indication **OR** B. BOTH of the following: 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication **AND** 2. There is support for why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit **OR** C. BOTH of the following: 1. The requested quantity (dose) exceeds than the maximum FDA labeled dose for the requested indication **AND** 2. There is support for therapy with a higher dose for the requested indication **Length of Approval:** up to 12 months