## **CAREFIRST - DC EXCHANGE 5T** Kerendia (HMF)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Kerendia (HMF).

Patient Information						
Patient Name:						
Patient Phone:						
Patient ID:						
Patient Group:						
Patient DOB:						
Physician Information						
Physician Name						
Physician Phone:						
Physician Fax:						
Physician Addr.:						
City, St, Zip:						
Drug Name (select from list of drugs shown)						
Kerendia (finerenone)						
	Frequency: Strength:					
Route of Administration: Expected Length of Therapy:					_	
	ICD Code:		_			
Comments:						
Please check the appropriate answer for each applicable question.						
1. Does the pa	atient have a diagnosis of chronic kidney disease (CKD) associa (T2D)?	ited with type	Y		N	
	nt currently receiving a maximally tolerated dose of an angiotens ibitor (ACEi) or angiotensin receptor blocker (ARB)?	sin-converting	Y		N	
	ient experienced an intolerance to an angiotensin-converting en CEi) or angiotensin receptor blocker (ARB)?	izyme	Y		N	
	atient have a contraindication that would prohibit a trial of an angenzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB)?	giotensin-	Y		N	
	dication requested is medically necessary for this patient. I furth and that the documentation supporting this information is availal					

processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

## Prescriber (Or Authorized) Signature and Date

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.