



finerenone (Kerendia™)

EOCCO POLICY



Policy Type: PA

Pharmacy Coverage Policy: EOCCO236

Description

Finerenone (Kerendia) is a selective, nonsteroidal mineralocorticoid receptor antagonist (MRA)

Length of Authorization

- Initial: 12 months
- Renewal: 12 months

Quantity Limits

Product Name	Dosage Form	Indication	Quantity Limit
finerenone (Kerendia)	10 mg tablets	Adjunct therapy for chronic kidney disease in type 2 diabetes	30 tablets/30 days
	20 mg tablets		

Initial Evaluation

- I. Finerenone (Kerendia) may be considered medically necessary when the following criteria are met:
 - A. Member is 18 years of age or older; **AND**
 - B. A diagnosis of **Type 2 Diabetes Mellitus (T2DM)** when the following are met:
 1. Member has chronic kidney disease (CKD) based on **one** of the following:
 - i. Estimated glomerular filtration rate (eGFR) is 60 mL/min/1.73m² or less for at least 3 months; **OR**
 - ii. Persistent moderate to severe albuminuria (urine albumin-to-creatinine ratio [UACR] 30 mg/g or greater, or 0.113 mg/mmol or greater) for at least 3 months; **AND**
 2. Documentation that treatment with an Angiotensin Converting Enzyme inhibitor (ACEI, e.g., lisinopril) or an Angiotensin Receptor Blocker (ARB, e.g., losartan) has been tried, unless all agents in these classes are contraindicated; **AND**
 - i. Provider attests that the treatment with an ACEI or ARB will be continued, unless all are contraindicated; **AND**
 3. Treatment with ONE Sodium Glucose Co-transporter-2 (SGLT2) inhibitor (e.g., empagliflozin (Jardiance), dapagliflozin (Farxiga)) has been ineffective, not tolerated, or all are contraindicated; **AND**
 4. Finerenone (Kerendia) will **not** be used in combination with a Sodium Glucose Co-Transporter-2 (SGLT2) inhibitor (e.g., empagliflozin (Jardiance), dapagliflozin (Farxiga)).

- II. Finerenone (Kerendia) is considered investigational when used for all other conditions, including but not limited to:
- A. Treatment of CKD in members less than 18 years of age
 - B. Treatment of hypertension
 - C. Treatment of cardiovascular disorder (e.g. myocardial infraction, heart failure)
 - D. Edema associated with nephrotic syndrome
 - E. Perioperative management of hyperaldosteronism

Renewal Evaluation

- I. Member has received a previous prior authorization approval for this agent through this health plan or has been established on therapy from a previous health plan; **AND**
- II. Member is not continuing therapy based off being established on therapy through samples, manufacturer coupons, or otherwise. If they have, initial policy criteria must be met for the member to qualify for renewal evaluation through this health plan; **AND**
 - A. Member has exhibited improvement or stability of disease symptoms (e.g. stabilization of eGFR, lack of hospitalization due to renal or cardiovascular disease); **OR**
 - B. In the absence of improvement or stability of disease symptoms, the provider attests that continuation of therapy is medically necessary AND clinical rationale of medical necessity has been provided and reviewed by a health plan clinician.

Supporting Evidence

- I. Finerenone (Kerendia) is a selective, nonsteroidal mineralocorticoid receptor antagonist (MRA) approved as an adjunct treatment to slow the progression of renal disease and to reduce the risk of cardiovascular (CV) outcomes in adult patients with chronic kidney disease (CKD) in type 2 diabetes (T2D). Efficacy and safety of finerenone (Kerendia) in the pediatric population has not been evaluated.
- II. MR overactivation may lead to inflammation and fibrosis and contribute to cardiorenal risk in T2D via hemodynamic and metabolic mechanisms. These are considered major drivers of heart and kidney damage in patients with CKD in T2D. Finerenone (Kerendia) reduces inflammation and fibrosis by blocking MR overactivation promoted by cardiorenal disease or diabetes. Finerenone (Kerendia) is the first non-steroidal MRA for adjunct treatment for cardiorenal risk reduction for CKD in T2D. Place in therapy for finerenone (Kerendia) is anticipated as an alternative to SGLT2 inhibitors.
- III. The KDIGO 2020 guideline for management of CKD in diabetes recommend control of hypertension and hyperglycemia, as well as use of renin-angiotensin blockers (e.g. ACEI, ARB).

Additionally, SGLT2 inhibitors (SGLT2i) have been recently approved as adjunct therapy to reduce cardiorenal risk in patients with CKD in T2D. Specifically, utility of choice of anti-diabetic drug regimen depends largely on the stage (severity) of CKD. For example, a combination of metformin and SGLT2i for T2D, is recommended when eGFR is ≥ 30 mL/min. Renin–angiotensin system (RAS) inhibition is recommended for patients with albuminuria and hypertension. For members whose CKD progresses despite treatment with metformin, ACEI and/or ARB, and SGLT2i (e.g. eGFR reduction $>30\%$, or progression to dialysis-dependence), additional antidiabetic therapy may be considered for glycemic control (e.g. GLP-1 agonist, DPP-4 inhibitors, insulin).

- IV. The clinical diagnosis of CKD in T2D is primarily based on the presence of albuminuria (urine-albumin-to-creatinine ratio [UACR] ≥ 30 mg/g) and/or eGFR < 60 mL/min/1.73 m² for ≥ 3 months, with the typical presentation generally considered to include a long duration of diabetes, albuminuria without hematuria, retinopathy, a gradually progressive decline in eGFR, and no other primary causes of kidney damage. Albuminuria is an essential marker for kidney disease, as well as a CV risk marker for myocardial infarction (MI) and stroke, in patients with T2D. Albuminuria is often the first clinical indicator of kidney disease, and frequently appears before a reduction in eGFR can be seen.
- V. Two randomized, double-blind, placebo-controlled, Phase 3 trials for finerenone (Kerendia) have been completed. The new drug application (NDA) for finerenone (Kerendia) was submitted to the US-FDA based on data from one randomized, double-blind, placebo-controlled, Phase 3 trial (FIDELIO-DKD) in 5,734 patients with CKD in T2D. The primary endpoint for FIDELIO-DKD was a composite renal outcome consisting of kidney failure, a sustained decrease of $\geq 40\%$ in eGFR, or death from renal causes. Composite CV outcomes were assessed as the key secondary endpoint. Another Phase 3 clinical trial (FIGARO-DKD) assessed composite CV outcomes as the primary endpoint, and composite renal outcomes as pre-specified secondary endpoint. Results for FIGARO-DKD are not published as of July 2021.
- VI. The FIDELIO-DKD participants consisted of adults (mean age 65) with diagnoses of T2D and CKD, with the majority of patients (52%) having an eGFR between 25 and 45 mL/min at baseline. All participants were pretreated with an ACEI, ARB, or both at maximum tolerated doses. Other baseline antihypertensive and antidiabetic medications (e.g. insulin, metformin, DPP-4 inhibitors) were also continued. Clinical trial data points to finerenone (Kerendia) as an adjunct to baseline therapy, specifically to ACEI or ARB. Although contraindication to all ACEI and ARB agents is rare, in such situations, coverage for finerenone (Kerendia) may be warranted without requiring concurrent therapy with an ACEI or ARB. Of note, adverse reactions to one agent in these therapeutic classes may not constitute as a class contraindication. Some examples of contraindication may include hypersensitivity reactions, severe angioedema, and persistent severe hyperkalemia.
- VII. The FIDELIO-DKD study demonstrated that, over a median follow-up period of 2.6 years, the primary composite renal outcomes was statistically significantly lower in the finerenone (Kerendia) group than the placebo group (17.8% [n= 504] vs 21.1% [n= 600]; HR: 0.82; (95% CI: 0.73, 0.93; p=0.001). Overall, 29 patients needed to be treated with finerenone (Kerendia) to

prevent one primary outcome event (number needed to treat [NNT]; 95% CI: 16, 166) based on an absolute risk reduction of 3.4% (95% CI: 0.6, 6.2) after three years.

- VIII. During the FIDELIO-DKD, only 4.3% (n= 124) participants were on SGLT2i at baseline and/or concurrently with finerenone (Kerendia). This trial was not powered to detect a difference in this subgroup (patients with and without concurrent SGLT2i use). Finerenone (Kerendia) did not provide renal risk reduction to this subgroup based on 14 primary endpoint events in the finerenone (Kerendia) arm versus 10 in the placebo arm (n=135); HR: 1.38 (95% CI: 0.61, 3.10). This indicates uncertainty around the effect size and clinical benefits of finerenone (Kerendia) in combination with SGLT2i in the real world setting. Although devoid of major safety concerns, additive efficacy, and applicability of finerenone (Kerendia) in combination with SGLT2 inhibitors remains uncertain.

Investigational or Not Medically Necessary Uses

- I. There are ongoing clinical studies to assess efficacy and safety of finerenone (Kerendia) in other settings. Notably, clinical trials in the settings of diabetic nephropathy, heart failure with systolic and diastolic dysfunction (HFpEF, HFrEF), non-diabetic kidney disease are underway. However, finerenone (Kerendia) does not have sufficient clinical evidence to support efficacy and safety, and has not been FDA-approved, for treatment of these conditions. Finerenone (Kerendia) is considered investigational when used for all other conditions, including but not limited to:
 - A. Treatment of CKD in members less than 18 years of age
 - B. Treatment of hypertension
 - C. Treatment of cardiovascular disorder (e.g. myocardial infraction, heart failure)
 - D. Edema associated with nephrotic syndrome
 - E. Perioperative management of hyperaldosteronism

Appendix

Table 1. Examples of baseline therapies for Chronic Kidney Disease (CKD) in Type 2 Diabetes Mellitus (T2DM)

Angiotensin-Converting Enzyme Inhibitors (ACEi)	Angiotensin II Receptor Blockers (ARB)	Sodium Glucose Co-Transporter-2 Inhibitors (SGLT2i)
benazepril	azilsartan	canagliflozin (Invokana)
captopril	candesartan	dapagliflozin (Farxiga)
enalapril	eprosartan	empagliflozin (Jardiance)
fosinopril	irbesartan	ertugliflozin (Steglatro)

lisinopril moexipril perindopril quinapril ramipril trandolapril	losartan olmesartan telmisartan valsartan	Combinations of SGLT2i with metformin and/ or other antidiabetic agents:
		cangliflozin+metformin (Invokamet) dapagliflozin+metformin (Xigduo XR) dapagliflozin+saxagliptin (Qtern) empagliflozin+linagliptin (Glyxambi) empagliflozin+metformin (Synjardy) empagliflozin+linagliptin+metformin (Trijardy XR)

References

1. Bakris GL, Agarwal R, Anker SD, Pitt B, Ruilope LM, Rossing P, Kolkhof P, Nowack C, Schloemer P, Joseph A, Filippatos G; FIDELIO-DKD Investigators. Effect of Finerenone on Chronic Kidney Disease Outcomes in Type 2 Diabetes. *N Engl J Med*. 2020 Dec 3;383(23):2219-2229.
2. Kidney Disease and Improving Global Outcomes (KDIGO) 2020 clinical practice guideline for diabetes management in chronic kidney disease; *J Int. Soc. Nephrol.*; 2020, 98 (45): Suppl 1; S1-S115.
3. Afkarian M, Sachs MC, Kestenbaum B, et al. Kidney disease and increased mortality risk in type 2 diabetes. *J Am Soc Nephrol*. 2013;24(2):302-308.
4. Chen TK, Knicely DH, et al. Chronic kidney disease diagnosis and management: a review. *JAMA*. 2019;322(13):1294-1304.
5. Grune J, Beyhoff N, Smeir E, et al. Selective mineralocorticoid receptor cofactor modulation as molecular basis for finerenone's antifibrotic activity. *Hypertension*. 2018;71(4):599-608.
6. Lovre D, Shah S, Sihota A, Fonseca VA. Managing diabetes and cardiovascular risk in chronic kidney disease patients. *Endocrinol Metab Clin North Am*. 2018;47(1):237-257.

Policy Implementation/Update:

Action and Summary of Changes	Date
Policy created	08/2021