Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Kerendia

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. The member does not have a contraindication to the requested drug (concomitant treatment with strong CYP3A4 inhibitors (e.g., itraconazole, clarithromycin), adrenal insufficiency, GFR less than 25 mL/min, serum potassium level greater than 5 mEq/L).

☐ Yes ☐ No

Q2. Is the request for initiation of treatment with Kerendia? If YES, go to 3. If NO, go to 9.

☐ Yes ☐ No

Q3. The member's lab results show ALL of the following:
a. Serum potassium is less than or equal to 5.0 mEq/L
b. Estimated glomerular filtration rate (eGFR) is greater than or equal to 25 mL/min/1.73 m^2
c. Urine albumin-to-creatinine ratio (UACR) is greater than or equal to 30 mg/g
If YES, go to 4.

☐ Yes ☐ No

Q4. The member has chronic kidney disease associated with type 2 diabetes. If YES, go to 5. If NO, go to 6.

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☐ Yes ☐ No

Q5. For chronic kidney disease associated with type 2 diabetes, ALL of the following:
a. The member has a documented diagnosis of chronic kidney disease associated with type 2 diabetes
b. Documentation shows concomitant therapy with an angiotensin-converting enzyme (ACE) inhibitor (e.g., lisinopril, ramipril) or angiotensin II receptor blocker (ARB) (e.g., losartan, irbesartan, valsartan) at maximally tolerated dose unless there is an intolerance or contraindication to these therapies

☐ Yes ☐ No

Q6. The member has heart failure with ventricular ejection fraction of 40 percent or greater. If YES, go to 7.

☐ Yes ☐ No

Q7. Documentation shows a diagnosis of heart failure with left ventricular ejection fraction of 40% or greater determined by ONE of the following tests:
a. Cardiac MRI
b. Nuclear medicine scans (MUGA)
c. Cardiac catheterization
If YES, go to 8.

☐ Yes ☐ No

Q8. Documentation shows concomitant therapy with one sodium-glucose co-transporter 2 (SGLT2) inhibitor (e.g., Farxiga or Jardiance) at maximally tolerated dose OR contraindication or intolerance to SGLT2 inhibitors.

☐ Yes ☐ No

Q9. The member has had a positive clinical response to therapy.

☐ Yes ☐ No

Q10. Additional Information:

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Patient Name:	**Prescriber Name:**

_____ _____

Prescriber Signature Date

v2025