

Kerendia (Finerenone)

EXCEPTION DRUG STATUS (EDS) REQUEST FORM

Fax: (204) 942-2030 or 1-877-208-3588

Prescriber Name:	Fax Number:	
Prescriber Address:	Phone Number:	Prescriber License Number (NOT Billing Number):
Patient's First Name:	PHIN:	MH Registration Number:
Patient's Last Name:	Patient's Date of Birth:	
Requested Medication Name and Strength:	Expected Dosing:	Expected Therapy Duration:

Exception Drug Status (EDS) approval is granted only upon demonstration that the patient meets the specified EDS criteria. Please provide the following details to support the meeting of EDS criteria by the patient.

For INITIAL Requests:				
Diagnosis/Indication: (check all that apply)	Type 2 Diabetes Mellitus			
	Chronic Kidney Disease			
	Other: _____			
Treatment History (provide information for ACEI or ARB and SGLT2):				
Name of Drug	Dosing Regimen	Start Date	End Date (if applicable)	Clinical Notes – if patient not on maximum dose, please indicate why. If contraindicated, please provide reason.
1. Angiotensin-converting enzyme (ACE) inhibitor OR Angiotensin-receptor blocker (ARB)				
AND 2. Sodium-glucose cotransporter 2 (SGLT2) inhibitor				
Is this patient receiving an alternative mineralocorticoid receptor antagonist (MRA)?				Yes No
Is finerenone being prescribed in consultation with a nephrologist, or by a prescriber with experience in the diagnosis and management of patients with CKD and T2D?				Yes No

For INITIAL and RENEWAL Requests:		
Patient Information		
	Result	Date Obtained
eGFR (mL/min/1.73 m ²)		
Urine albumin-creatinine ratio (uACR)		
New York Heart Association (NYHA) Class		

Prescriber Signature and Date:	
Date:	Prescriber Signature: