Kerendia (Finerenone)

EXCEPTION DRUG STATUS (EDS) REQUEST FORM

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

Prescriber Name:	**Fax Number:** **Phone Number:**
Prescriber Address:	**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: