



To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

- You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week,  
TTY users: 1-800-716-3231
- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: [medicarepartdparequests@express-scripts.com](mailto:medicarepartdparequests@express-scripts.com)

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:
Medication:	Diagnosis:

**SECTION A**

Please answer the following questions

1.    ☐ Yes    ☐ No    Will Kerendia be used concomitantly with spironolactone or eplerenone?
2.    ☐ Yes    ☐ No    Is the member currently receiving a maximally tolerated labeled dosage of an angiotensin converting enzyme (ACE) inhibitor (for example, benazepril, enalapril, lisinopril, ramipril, etc.) or angiotensin receptor blocker (ARB) (for example, losartan, candesartan, olmesartan, valsartan, irbesartan, etc.) or is the member contraindicated for these therapies?
3.    ☐ Yes    ☐ No    Is the member greater than or equal to 18 year(s) of age?
4.    ☐ Yes    ☐ No    Is the diagnosis or indication for the treatment of chronic kidney disease associated with type 2 diabetes? *(if NO, skip to question 6)*
5.    ☐ Yes    ☐ No    Has Kerendia been previously authorized by SCAN Health Plan for this member? *(if NO, skip to question 8)*
6.    ☐ Yes    ☐ No    Is the diagnosis or indication for the treatment of heart failure with left ventricular ejection fraction (LVEF) greater than 40%?

7.    ☐ Yes    ☐ No    Has Kerendia been previously authorized by SCAN Health Plan for this member?
8.    ☐ Yes    ☐ No    Does the member have an estimated glomerular filtration rate (eGFR) greater than or equal to 25 mL/min/1.73 m<sup>2</sup>?
9.    ☐ Yes    ☐ No    Does the member have a urine albumin-to-creatinine ratio greater than or equal to 30mg/g?
10.   ☐ Yes    ☐ No    Does the member have a serum potassium level less than or equal to 5.0 mEq/L?

***Please document the symptoms and/or any other information important to this review:***

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**SECTION B**

Physician Signature

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PHYSICIAN SIGNATURE

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DATE

**FAX COMPLETED FORM TO: 1-877-251-5896**

Our response time for prescription drug coverage standard requests is 72 hours. If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received. View our formulary and Prior Authorization criteria online at <http://www.villagehealthca.com>