BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

Finerenone Prescribing/ Monitoring Checklist for Diabetic Kidney Disease

(February 2025)

The recommendations in this prescribing/monitoring checklist document have been adopted with kind permission from Buckinghamshire, Oxfordshire, and Berkshire (BOB) Integrated Care System (ICS) medicines optimisation team and supported by East and North Hertfordshire NHS Trust Renal Team. It aligns with current recommendations in the NICE Technology Appraisal (NICE TA 877); Finerenone for treating chronic kidney disease in type 2 diabetes and should be read in conjunction with the corresponding Summary of Products Characteristics (SPC).

The following organisations contribute to and participate in the BLMK APC – Bedfordshire, Luton and Milton Keynes Integrated Care Board; Bedfordshire Hospitals NHS Foundation Trust; Cambridgeshire Community Services NHS Trust; Central and Northwest London NHS Foundation Trust; East London NHS Foundation Trust; Milton Keynes University Hospital NHS Foundation Trust.

Approved by BLMK Area Prescribing Committee (APC): February 2025. Review Date: February 2028

Finerenone Prescribing/Monitoring Checklist for Chronic Kidney Disease in Type 2 diabetes

Finerenone is a novel, non-steroidal, selective mineralocorticoid receptor antagonist (MRA) that is used for patients with stage 3 and 4 chronic kidney disease (CKD) associated with type 2 diabetes (T2DM) in adults.

Finerenone is an add-on therapy to optimise standard of care (SoC) for patients with stage 3 or 4 CKD with albuminuria and T2DM; this should include, unless they are unsuitable, the highest tolerated licensed doses of:

- angiotensin-converting enzyme inhibitors (ACEIs) or angiotensin receptor blockers (ARBs) and;
- Sodium-glucose co-transporter-2 (SGLT2) inhibitors and;
- patient has urinary albumin: creatinine (uACR) ration of greater than 3mg/mmol and;
- patient has an eGFR of 25 mL/min/1.73 m^2 or more.

Transient decline in eGFR may be observed on the initiation of finerenone. This is reversible during continuous treatment.

The benefits of finerenone include reducing albuminuria, slowing the CKD progression and reducing risk of cardiovascular events.

Global management of cardiovascular and renal risks in CKD patients with T2DM	
RECOGNISE	• Case finding/standard care
TREAT	• ACEIs/ARBs • SGLT2 inhibitors • BP targeting. BP <130/80mmHg • Finerenone • Glycaemic control
REDUCE CV RISK	• Lipids & lifestyle changes • Smoking cessation, regular aerobic exercise, weight and BMI reduction

Prescribing/monitoring checklist

Initiation criteria	**To confirm**
eGFR is ≥ 25 mL/min or ≤ 60mL/min	☐
uACR of greater than 3mg/mmol	☐
Diagnosis of T2DM	☐
On highest tolerated dose of ACEIs or ARBs	☐
On SGLT2 inhibitors unless contraindicated	☐
No prior allergy or intolerance to finerenone or other MRAs	☐
No concomitant use of other MRAs (i.e., spironolactone, eplerenone) or potassium-sparing diuretics (i.e., amiloride)	☐
No history of severe hepatic impairment	☐
No history of Addison's disease	☐
Serum potassium < 5.0mmol/L	☐
Baseline blood tests	
• Serum potassium level • eGFR	☐ ☐
Patient education	
Finerenone should not be taken concomitantly with: • Grapefruit or grapefruit juice	☐

• Strong CYP3A4 inhibitors (i.e., clarithromycin, ritonavir, itraconazole) • Strong CYP3A4 inducers (i.e., rifampicin, carbamazepine, phenytoin, phenobarbital, St John's Wort)	☐ ☐
Tablet may be crushed and mixed with water or soft foods	☐
Finerenone should be avoided in pregnancy unless benefit outweighs risk N/A	☐ ☐
Women of childbearing potential should use effective contraception during finerenone treatment N/A	☐ ☐
Avoid breastfeeding unless potential benefit outweighs risk N/A	☐ ☐
Follow-up	
Repeat serum potassium and renal function: • Four weeks after initiation, restarting treatment or dose change	☐

Dosing

Treatment initiation

Serum potassium level (mmol/L)	
≤ 4.8	Start finerenone
>4.8 to 5.0	Finerenone may be considered with additional serum potassium monitoring within the first 4 weeks, based on the patient's co-morbidities and subsequent potassium levels.
> 5.0	Do not start finerenone
eGFR (mL/min/1.73m^2)	
≥ 25 to < 60	Start 10mg daily
< 25	Do not start finerenone

Dose adjustment / Continuation of treatment

Serum potassium level (mmol/L)	**Current finerenone dose (once daily)**	
	10mg	**20mg**
≤ 4.8	Increase to 20 mg finerenone once daily (Maintain 10mg daily if eGFR has decreased more than 30% compared to the previous measurement)	Continue
> 4.8 to 5.5	Continue	
> 5.5	Withhold finerenone. Re-start at 10 mg once daily when serum potassium ≤ 5.0 mmol/L.	
eGFR (mL/min/1.73m^2)		
Stop finerenone in end-stage renal disease with eGFR < 15mL/min/1.73m^2		

Monitoring

As with other MRAs, it is recommended that potassium, creatinine and eGFR are checked after initiation, restarting treatment or dose change.

Ongoing monitoring of renal function is in line with usual CKD care in accordance with NICE Guideline NG203.

CKD stage	Suggested monitoring frequency
3	Every 4 to 6 months
4	Every 3 months

Contact details for advice

East and North Hertfordshire	• Via Advice and Guidance
Buckinghamshire and Oxfordshire	• Renal Specialist Advice: renaladvice@ouh.nhs.uk • Oxford Renal Pharmacy Team: oxfordrenalpharmacists@ouh.nhs.uk

References

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