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| Renal Directorate Guidelines  Royal Infirmary of Edinburgh |

**Finerenone**

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| **Indication and additional information** | **Treatment of chronic kidney disease (Stage 3 and 4 with albuminuria) associated with Type 2 diabetes in adults**  Finerenone is a non-steroidal mineralocorticoid antagonist, which is associated with a lower incidence of hyperkalaemia than spironolactone in clinical trials.  In the FIDELIO trial it reduced the risk of end-stage kidney disease, renal-related death or >40% reduction in GFR by 18% compared to standard of care in patients with diabetic kidney disease and eGFR 25-60ml/min and moderately elevated albuminuria (ACR 3-30 mg/mmol) or patients with eGFR 25-75ml/min and severely elevated ACR (30-500).  Similarly, in the FIGARO trial, it reduced cardiovascular end-points by 17% compared to standard care in a comparable cohort of patients with type 2 diabetes. |
| **Criteria for treatment** | Addition of finerenone should be considered to reduce the risk of adverse kidney and cardiovascular outcomes in people:  · with T2DM and CKD who have persistent albuminuria:  If ACR>3mg/mmol and eGFR 25-60ml/min  If ACR>30mg/mmol (PCR >50mg/mmol) and eGFR >60ml/min (No maximum eGFR as upper limit cannot be measured accurately)  · who are already on maximum tolerated dose of RASi and SGLT2i (or if contraindicated or not tolerated)  · who typically have serum potassium concentrations < 5 mmol/L |
| **Dosage and monitoring** | **Initiation**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **eGFR** | **Initial Potassium** | **≤4.8mmols/L** | **>4.8-5.0 mmols/L** | **>5.0mmols/L** | | **≥60ml/min** | | 20mg once daily | 20mg once daily with additional potassium monitoring | Initiation not recommended | | **25-60ml/min** | | 10mg once daily | 10mg once daily with additional potassium monitoring | Initiation not recommended | | **<25ml/min** | | Initiation not recommended (but if already on treatment then can continue to eGFR of 15ml/min) | | |   **Monitoring**  If starting serum potassium ≤4.8mmols/L check serum potassium and eGFR **FOUR** weeks after initiation. If starting potassium >4.8-5.0 mmols/L do an additional serum potassium and eGFR at **TWO** weeks (then at **FOUR** weeks).  **Continuation (after four weeks)**   |  |  |  |  | | --- | --- | --- | --- | |  |  | **On 10mg initiation dose** | **On 20mg initiation dose** | | **Serum potassium (mmol/L)** | ≤4.8 | Increase to 20mg once daily | Maintain 20mg once daily | | >4.8-5.5 | Maintain 10mg once daily | Maintain 20mg once daily | | >5.5 | Withhold finerenone\* | Withhold finerenone\* |   \*Consider restarting at 10mg once daily when serum potassium ≤5.0mmol/L  NB: If eGFR has decreased by >30% from baseline then maintain dose at 10mg daily  Recheck serum potassium and eGFR **FOUR** weeks after any changes in dose. Thereafter check serum potassium and eGFR at periodic intervals as needed based on patient characteristics and serum potassium levels.  The maximum dose is 20mg once daily.  **Stopping**  Finerenone should be discontinued in patients when eGFR ≤15ml/min. |
| **Cautions/Side Effects** | Please see summary of product characteristics at [www.medicines.org.uk](http://www.medicines.org.uk) |
| **Patient Counselling** | Avoid grapefruit juice. Give potassium and sick day rules advice- full information in Patient information leaflet at [www.medicines.org.uk](http://www.medicines.org.uk) |
| **Drug Interactions** | Moderate and weak CYP3A4 inhibitors, potassium supplements, potassium sparing diuretics, trimethoprim or co-trimoxazole: additional serum potassium monitoring should be considered or temporary discontinuation of finerenone.  Concomitant administration with grapefruit juice and strong inhibitors of CYP3A4 (e.g. itraconazole, ketoconazole, ritonavir, nelfinavir, clarithromycin) is contraindicated  Concomitant administration with strong and moderate CYP3A4 inducers (e.g. carbamazepine, phenytoin, phenobarbital, St John’s Wort) is not recommended as they markedly decrease finerenone plasma concentration. |

Please see full summary of product characteristics at: [www.medicines.org.uk](http://www.medicines.org.uk)