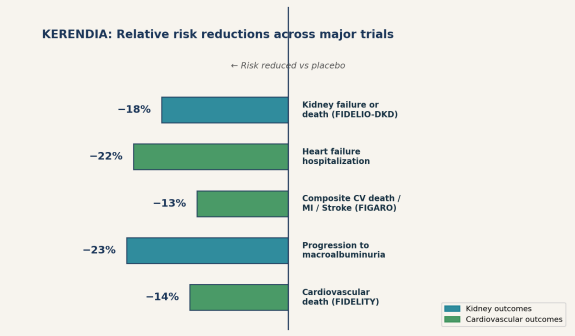
Understanding KERENDIA (Finerenone)

Heart and kidney protection for patients with CKD and type 2 diabetes

One pill. Two organs protected. Potassium watched.



Online: https://go.riasalimd.com/kerendia-guide

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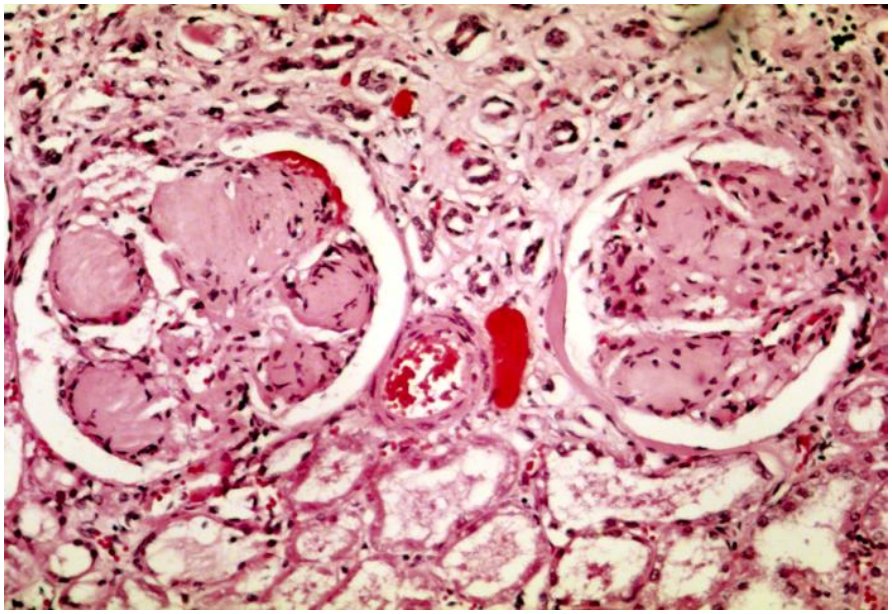
Last Updated: August 2026

Names & Terms You Will Hear

Term	Meaning
KERENDIA	The brand name for finerenone in the United States.
Finerenone	The generic name. It is a nonsteroidal MRA, a newer kind of heart and kidney drug.
Nonsteroidal MRA	A newer class of heart and kidney drug. It blocks the harm aldosterone does. It skips some side effects of older MRAs like spironolactone.
Mineralocorticoid receptor antagonist (MRA)	A drug that blocks a hormone. That hormone drives swelling, fluid buildup, and scarring in the heart and kidneys.
CKD (Chronic Kidney Disease)	Long-term kidney damage. It is graded by GFR (filter rate) and by albumin in the urine. KERENDIA is approved for stages G3 to G4 with type 2 diabetes.
eGFR	Estimated GFR. It is the main way we measure how well your kidneys clean the blood. We use it to dose KERENDIA.
Hyperkalemia	Too much potassium in the blood. This is the main safety concern with KERENDIA. You need lab checks before and during treatment.

What Is KERENDIA (Finerenone)?

- KERENDIA (finerenone) is a once-a-day pill. It guards both the heart and the kidneys. It is for people who have chronic kidney disease from type 2 diabetes.
- It is a nonsteroidal MRA. It blocks a hormone called aldosterone. When that hormone runs too high, it drives swelling and scarring in the heart and kidney.
- KERENDIA is not like older MRAs such as spironolactone or eplerenone. It acts in a more targeted way. So it skips hormone side effects like breast tenderness or sexual problems.
- It does NOT lower blood sugar, blood pressure, or cholesterol on its own. Instead, it guards the tissue from a kind of damage that runs alongside those risks.
- KERENDIA is approved for adults who have CKD stage G3 to G4, high urine albumin, and type 2 diabetes. Most take it on top of an ACE inhibitor or ARB and an SGLT2 inhibitor.



A real kidney biopsy under the microscope, from a patient with diabetic nephropathy. The round, layered pink nodules inside the round filters (glomeruli) are Kimmelstiel-Wilson nodules — this is the scarring pattern that aldosterone-driven damage builds over time, and what KERENDIA is designed to slow. Image: Centers for Disease Control and Prevention (Public Domain).

Why It Matters

- The FIDELIO-DKD trial had 7,437 patients. KERENDIA cut the risk of kidney failure or heart-related death by 18%. That was over about 2.5 years, next to placebo.
- The FIGARO-DKD trial had 7,352 patients. KERENDIA cut a group of events by 13%. That group was heart-related death, heart attack, stroke, and heart failure hospital stays.
- The FIDELITY analysis pooled 13,000 patients. KERENDIA cut heart failure hospital stays by 22%. It also slowed the loss of kidney function.
- CKD plus type 2 diabetes is one of the riskiest pairings in heart care. Bad kidneys speed up heart disease. Heart disease speeds up kidney decline. KERENDIA works on the swelling-and-scarring path they share.
- SGLT2 inhibitors cut fluid load. Finerenone works on a different problem: the scarring that aldosterone drives in heart and kidney tissue. So the two drugs help in different ways. They work together, not against each other.

Treatment Options

- Starting dose: 10 mg once a day if your eGFR is 25 to 59. The dose is 20 mg once a day if your eGFR is 60 or higher.
- Check potassium before you start. Do not start if K+ is over 5.0 mEq/L. Wait until potassium is back in the safe zone.
- Check potassium again 4 weeks after you start, then on a set schedule. At 4 weeks, your potassium and kidney numbers decide if the dose stays at 10 mg or goes up to 20 mg.
- Take it once a day, with or without food. If pills are hard to swallow, you can crush the tablet in water or applesauce.
- Skip grapefruit and grapefruit juice. They raise finerenone levels and raise the risk of high potassium.
- Tell every provider you take KERENDIA. That means your pharmacist and your dentist too. It can react with some antifungal pills and some HIV drugs.
- KERENDIA works best as one of four drugs: an ACE inhibitor or ARB, an SGLT2 inhibitor, a GLP-1 agonist if you need one, and finerenone. Your heart or kidney doctor sets up the full plan.

Risks, Benefits, and Alternatives

Every choice has trade-offs. Use this table to start the shared decision conversation.

Option	Risks	Benefits	Alternatives
KERENDIA (finerenone)	Can raise potassium. That is the top reason to pause or stop it. It may lower blood pressure or sodium. You need lab checks every 4 weeks at first.	Cuts kidney failure or heart death by 18%. Cuts heart failure hospital stays by 22%. Cuts a group of heart events by 13%. Slows kidney scarring. Works a different way than an SGLT2 inhibitor, so the help adds up.	An SGLT2 inhibitor by itself (does less for kidney scarring). An old MRA like spironolactone (more hormone side effects). Or no add-on drug at all.
SGLT2 inhibitor (empagliflozin, dapagliflozin)	Genital yeast and urine infections. Dehydration. Rare DKA. You need an eGFR above 20 to 25 to start.	Cuts heart failure hospital stays by 30 to 35%. Slows kidney disease by easing pressure in the kidney filters. Drops body weight by 4 to 6 lb. Works well alongside finerenone.	Finerenone (works a different way). An ACE inhibitor or ARB by itself. Or no add-on drug.
ACE inhibitor or ARB (such as lisinopril, losartan)	An ACE inhibitor can cause a cough. Potassium may rise. Kidney numbers may dip in the first weeks. Rare swelling under the skin with an ACE inhibitor.	Cuts protein in the urine. Slows kidney decline. Lowers heart risk. It is the base of CKD plus diabetes care. KERENDIA goes on top of it.	An ARB in place of an ACE inhibitor (no cough). Guidelines do not back an SGLT2 inhibitor plus finerenone with no ACE inhibitor or ARB.

Option	Risks	Benefits	Alternatives
No added kidney or heart protection	Kidneys keep slipping (about 4 to 8 mL/min lost each year). Higher risk of heart failure hospital stays. Higher risk of major heart events over 3 to 5 years.	No drug changes. No lab burden.	Adding KERENDIA plus an SGLT2 inhibitor on top of an ACE inhibitor or ARB is now the standard for CKD G3 to G4 with diabetes and high albumin.

Common Misconceptions

Myth	Reality
KERENDIA is just a water pill like spironolactone.	It is a different drug that aims at a different target. Spironolactone pulls off fluid and is used in heart failure. KERENDIA slows scarring in the kidney and heart in a more targeted way. It pulls off far less fluid and has fewer hormone side effects.
If my potassium is already a little high, KERENDIA isn't for me.	Not always. The cutoff is K+ over 5.0 mEq/L. If your potassium is just a bit high (4.6 to 5.0), we can often bring it down first. We may change your diet, add a potassium binder, or use a water pill. Then we can start KERENDIA safely. Ask us about your own number.
KERENDIA is the same as SGLT2 inhibitors (Jardiance, Farxiga).	They work in totally different ways. SGLT2 inhibitors take some sodium and sugar load off the kidney. That guards it through pressure. KERENDIA blocks aldosterone, the scarring hormone. That guards it through less scarring. Most guidelines now call for both in CKD plus diabetes with heart risk.
I don't need KERENDIA if my diabetes is well controlled.	CKD still moves ahead through swelling and scarring, even with a good A1c. Finerenone works on those paths apart from blood sugar. Patients in the trials had a good A1c at the start and still gained.
KERENDIA is only for people with heart failure.	KERENDIA is mainly approved for CKD plus type 2 diabetes, to guard the kidney and heart. It is not just for heart failure. The newer FINEARTS-HF trial points to help in some heart failure too, but that proof is still growing.
If I feel fine, I don't need to get my potassium checked.	High potassium can get bad with no warning signs until it is very high. The first lab check at 4 weeks is a must. You still need it even if you feel well.

Myth	Reality
KERENDIA lowers blood sugar.	It does not. KERENDIA does nothing to your blood sugar, your A1c, or how your body uses insulin. It guards the heart and kidney through a fully separate hormone path.

Possible Complications

Knowing what can go wrong helps you spot problems early. Most complications are uncommon, especially with treatment.

Where / What	What Can Happen
Hyperkalemia (high potassium)	This is the top risk. It happens in 10 to 15% of patients. Very high potassium (K+ over 6.0) is rare, but it can set off a dangerous heart rhythm. Routine lab checks stop most bad events.
Hypotension (low blood pressure)	Less common with finerenone than with older MRAs. Watch for dizziness when you stand up. It is most likely in the first few weeks, or if you also take a water pill.
Hyponatremia (low sodium)	Rare. It is most likely if you already take a water pill or drink very little. Tell us about odd tiredness, headache, or confusion.
Drug interactions	Your liver breaks down finerenone. Some drugs slow that process. Certain antifungal pills and some HIV drugs can double the finerenone in your blood. That sharply raises the risk of high potassium.
Brief dip in kidney function	A small rise in creatinine in the first weeks is normal. It is not a reason to stop. It settles down. This is not the same as ongoing kidney damage.

Points to Know

If you remember nothing else, remember these key points.

- Get your potassium checked before you start and again at 4 weeks. This is the key safety step. It is not optional.
- Safe potassium on KERENDIA: below 5.0 mEq/L to start. It must be below 4.8 mEq/L to go from 10 mg up to 20 mg.
- Stay off grapefruit and grapefruit juice the whole time you take KERENDIA.
- KERENDIA can react with common antifungal pills (fluconazole, itraconazole) and some HIV drugs. Tell every prescriber.
- Call us if you start any new drug or supplement that has potassium in it. That includes salt swaps like Nu-Salt.
- You can crush it if you need to. Mix it in water or applesauce and take it right away. Do not save the mix.
- KERENDIA does not take the place of your ACE inhibitor, ARB, or SGLT2 inhibitor. It works next to them as a fourth pill.
- Each year you need a kidney check (eGFR and a urine albumin test) plus potassium checks. Keep every lab visit.

When to Call Us - and When to Call 911

If you are not sure, call. We would rather hear from you twice than miss a real problem.

- Muscle weakness, cramps, or floppiness — call us today (possible high potassium).
- Irregular heartbeat, pounding, or palpitations — call us today.
- Numbness or tingling in hands, feet, or lips — call us today (potassium symptom).
- Severe dizziness, lightheadedness, or fainting — call us today.
- New ankle or leg swelling — call us this week.
- Starting any new prescription — especially antifungals, HIV drugs, or supplements with potassium — call us first.
- Chest pain, sudden shortness of breath, or severe fatigue — call 911.
- Before any surgery, contrast scan, or dental procedure — call us about your medication regimen.

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Trusted Resources

The links below are the trusted resources Dr. Ali used to write this guide and that he recommends you visit for more information. Each is a clickable link in the digital version and a Short.io tracked URL on the printed version.

- Cleveland Clinic — Finerenone (Kerendia) - A drug page for patients. It covers the dose, side effects, and lab checks.
- MedlinePlus — Finerenone - Drug facts from the NIH. It covers drug mixes and how to store it.
- National Kidney Foundation — CKD Information - Patient pages on the stages of kidney disease, diet, and care.
- American Heart Association — Diabetes and Heart Disease - AHA pages on how diabetes and the heart are linked, and how to lower risk.

Sources Used to Build This Guide

Every recommendation in this guide is grounded in one or more of the studies, guidelines, or trusted resources below. Short links are tracked so Dr. Ali can see which references patients are reading; nothing personally identifying is captured.

- FIDELIO-DKD — Finerenone in CKD and Type 2 Diabetes (Bakris et al, NEJM 2020) *[Clinical Trial]*
  Pivotal RCT: finerenone reduced kidney failure and cardiovascular events in CKD + T2DM vs placebo. Foundation for kidney-protection framing.
- FIGARO-DKD — Cardiovascular Outcomes with Finerenone (Pitt et al, NEJM 2021) *[Clinical Trial]*
  Companion RCT to FIDELIO-DKD: finerenone cut composite cardiovascular death/MI/stroke/HF hospitalization by 13%. Anchors the heart-protection section.
- FINEARTS-HF — Finerenone in HFmEF/HFpEF (Solomon et al, NEJM 2024) *[Clinical Trial]*
  Extends finerenone evidence to heart failure with preserved/mildly reduced EF. Supports discussion of broader CV benefit and emerging HFpEF use.
- FIDELITY — Pooled analysis of FIDELIO-DKD + FIGARO-DKD (Agarwal et al, Eur Heart J 2022) *[Clinical Trial]*
  13,000-patient pooled analysis confirming CV and kidney benefits across CKD stages. Cited for magnitude-of-benefit statistics.
- AHA/ACC Consensus Decision Pathway — Novel Therapies in Cardiometabolic Disease (2023) *[Guideline]*
  Positions finerenone within the cardiometabolic treatment algorithm alongside SGLT2i and GLP-1 RA for CKD + T2DM + CV disease.
- KDIGO 2022 Clinical Practice Guideline for Diabetes Management in CKD *[Guideline]*
  KDIGO positions finerenone as a recommended add-on in CKD G3-G4 with T2DM when eGFR permits. Establishes potassium monitoring protocol.
- Cleveland Clinic — Finerenone (Kerendia) *[Clinical]*
  Patient-friendly drug profile covering dosing, monitoring, and hyperkalemia warning signs.
- MedlinePlus — Finerenone *[Clinical]*
  NIH-curated patient drug information including interactions, storage, and missed-dose guidance.

About This Guide

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Version: 2026-08-15

Reviewer note: Reviewed against Kerendia HCP brochure, Cleveland Clinic, and AHA/ACC 2023 cardiometabolic pathway. Ours adds: visual risk-reduction chart across FIDELIO + FIGARO + FIDELITY, explicit hyperkalemia monitoring protocol, potassium safe-zone guide, and comparison to SGLT2i/GLP-1 RA in the combination algorithm.

Disclaimer

This guide is for educational purposes only and does not replace medical advice from your physician. Recommendations may not apply to every patient. Always follow the specific instructions of Dr. Ali and your care team. In an emergency call 911 or go to the nearest emergency department.

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