SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Tryngolza® (olezarsen)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Requested Medication is ONE of the following:

- ❑ New Start
- ❑ Continuation of therapy – provide therapy start date: _____

Quantity Limit: One autoinjector per 30 days (all strengths)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Diagnosis: Familial Chylomicronemia Syndrome**

Recommended Dosage: 80 mg injected subcutaneously once monthly.

Initial Authorization: 12 months

- ❑ Member is 18 years of age or older

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- ❑ Prescribed by or in consultation with a cardiologist, endocrinologist, or a specialist experienced in treating severe hypertriglyceridemia
- ❑ Member has a diagnosis of Familial Chylomicronemia Syndrome confirmed by **ONE** of the following:
  - ❑ Genetic testing showing biallelic pathogenic variants in FCS-causing genes (LPL, LMF1, GPIHBP1, APOC2, APOA5) **(submit results of genetic testing)**
  - ❑ Genetic testing is inconclusive, and the member has North American familial chylomicronemia syndrome (NAFCS) score ≥ 45 ("probable or definite FCS") or Moulin score ≥ 10 ("FCS very likely") **(submit copy of NAFCS or Moulin scoring with results)**
- ❑ Member has fasting triglyceride level ≥ 880 mg/dL **(submit lab results from the past 30 days)**
- ❑ Requested medication will be used as an adjunct to a low-fat diet (≤ 20 g of fat per day)
- ❑ Tryngolza® will **NOT** be used in combination with Redemplo® (plozasiran)

❑ Diagnosis: Familial Chylomicronemia Syndrome

Reauthorization: 12 months. All criteria that apply must be checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- ❑ Member has experienced positive clinical response from the medication as demonstrated by improvement in fasting triglyceride levels from baseline **(submit lab results from the past 90 days)**
- ❑ Requested medication will continue to be used as an adjunct to a low-fat diet (≤ 20 g of fat per day)
- ❑ Member has **NOT** experienced serious adverse events related to the medication (e.g. thrombocytopenia, hypersensitivity to olezarsen)

❑ Diagnosis: Severe Hypertriglyceridemia

Recommended Dosage: 50 mg injected subcutaneously once monthly. For patients who tolerate the 50 mg dosage and additional triglyceride reduction is clinically indicated, the dosage may be increased to 80 mg injected subcutaneously once monthly.

Initial Authorization: 12 months

- ❑ Member is 18 years of age or older with a confirmed diagnosis of severe hypertriglyceridemia
- ❑ Lifestyle & diet modifications and lipid lowering therapies have been optimized and will be continued with the requested drug
- ❑ Member has had an unsuccessful 3-month trial with **BOTH** of the following prescription therapies at maximally tolerated doses **(verified by labs and pharmacy paid claims and/or chart notes. Documentation must be submitted if there is intolerance and/or contraindications to therapies.)**
  - ❑ Fibrate therapy (e.g. fenofibrate)
  - ❑ Omega-3 fatty acids (e.g. omega-3 acid ethyl esters, icosapent ethyl*)(*Requires prior authorization)
- ❑ Member's current fasting triglyceride level remains ≥ 500 mg/dL despite treatment with triglyceride-lowering therapies **(submit lab results from the past 30 days)**

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- ❑ If fasting triglyceride level is ≥ 880 mg/dL, familial chylomicronemia syndrome has been ruled out
- ❑ Tryngolza® will **NOT** be used in combination with Redemplo® (plozasiran)

❑ Diagnosis: Severe Hypertriglyceridemia

Reauthorization: 12 months. All criteria that apply must be checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- ❑ Member has experienced positive clinical response from the medication as demonstrated by improvement in fasting triglyceride levels from baseline **(submit lab results from the past 90 days)**
- ❑ Requested medication will continue to be used as an adjunct to a low-fat diet
- ❑ Background therapy with traditional triglyceride-lowering drugs will be continued (unless intolerances and/or contraindications are present)
- ❑ Member has **NOT** experienced serious adverse events related to the medication (e.g. thrombocytopenia, hypersensitivity to olezarsen)

Medication being provided by Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee:** ~~3/27/2025; 1/22/2026;~~ **9/24/2026**
REVISED/UPDATED/REFORMATTED: ~~4/15/2025; 2/16/2026;~~ **10/16/2026**