

# SENTARA COMMUNITY PLAN (MEDICAID)

## 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:** Redemplo<sup>®</sup> (plozasiran)

**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: \_\_\_\_\_

**Quantity Limit:** 25 mg/0.5 mL syringe – one syringe per 90 days

**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.

**Initial Authorization: 12 months**

- Member is 18 years of age or older
- 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 (FCS) that is supported by genetic testing showing biallelic pathogenic variants in FCS-causing genes (LPL, LMF1, GPIHBP1, APOC2, APOA5) (submit results of genetic testing)

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- Requested medication will be used as an adjunct to a low-fat diet ( $\leq 20$  g of fat per day)
- Member has fasting triglyceride level  $\geq 880$  mg/dL (**submit lab results from the past 30 days**)
- Redemplo<sup>®</sup> will **NOT** be used in combination with Tryngolza<sup>®</sup> (olezarsen) (**verified by chart notes and pharmacy paid claims**)

**Reauthorization: 12 months.** 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.

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

**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.\****