

AvMed

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 1-305-671-0200.** 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® (plozasiran)

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

Member Name: _____

Member AvMed #: _____ 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**)
- Requested medication will be used as an adjunct to a low-fat diet (≤ 20 g of fat per day)

(Continued on next page)

- Member has fasting triglyceride level ≥ 880 mg/dL (**submit lab results from the past 30 days**)
- Redemplo[®] will **NOT** be used in combination with Tryngolza[®] (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 (≤ 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.****