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: 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:** _____

Quantity Limit: 50 mg/0.8 mL autoinjector or 80 mg/0.8 mL autoinjector – one autoinjector per 30 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
- ❑ Member has a diagnosis of familial chylomicronemia syndrome confirmed by **one** of the following:
  - ❑ Genetic confirmation of bi-allelic pathogenic variants in affected genes (e.g., LPL, ApoA5, ApoC2, LMF1, GPIHBP1, G3PDH1) **OR**

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- ❑ **ALL** of the following:
  - ❑ Fasting triglyceride (TG) levels greater than 880 mg/dL for 3 consecutive measurements
  - ❑ Secondary causes of hypertriglyceridemia have been ruled out (e.g., alcohol use, chronic kidney disease, hypothyroidism, uncontrolled diabetes, medications [e.g., atypical antipsychotics, beta-blockers, corticosteroids, oral estrogens])
  - ❑ History of pancreatitis or unexplained recurrent abdominal pain **OR**
- ❑ Medication will be used to reduce triglycerides and the risk of acute pancreatitis in adults with severe hypertriglyceridemia
- ❑ Member has had a treatment failure, maximum dosing with, or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants
- ❑ Provider attests that this medication will be used as an adjunct to diet
- ❑ List previous medications **(include drug name/dose):**

_____

_____

_____

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 continues to meet the relevant criteria identified in the initial criteria
- ❑ Member continues to experience clinical benefit from the requested treatment
- ❑ 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.*

***Approved by Pharmacy and Therapeutics Committee:** ~~3/27/2025;~~ **1/22/2026**
REVISED/UPDATED/REFORMATTED: ~~4/15/2025; 2/18/2026,~~ **8//7/2026**