

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: Tryngolza[®] (olezarsen)

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: 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
- 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**)
- 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)

(Continued on next page)

- ❑ Member meets **ONE** of the following:
 - ❑ Member has had an inadequate response after an adherent 6-month trial of Redemplo[®] (plozasiran) and prescriber has submitted medical reasoning as to why Tryngolza[®] is expected to have a superior clinical effect compared to Redemplo (verified by pharmacy paid claims and chart note documentation which may include but is not limited to the number of new hospitalizations due to acute pancreatitis, record of member's dietary fat intake, pre- and post-treatment triglyceride lab results, etc.)
 - ❑ Member has experienced an adverse reaction to Redemplo[®] (plozasiran). Provider must submit clinical chart notes **AND** a completed MedWatch form documenting the experienced treatment failure or intolerance to Redemplo[®] (verified by chart notes and pharmacy paid claims)
 - ❑ Tryngolza[®] will **NOT** be used in combination with Redemplo[®] (plozasiran) (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 (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.****