Tryngolza (olezarsen)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Familial chylomicronemia syndrome ☐ Hypertriglyceridemia ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Will the patient be using the drug as a part of the clinical trial? ☐ **Yes** ☐ **No**

Will Tryngolza (olezarsen) be used in combination with a very low-fat diet, less than 20 gm of fat per day? ☐ **Yes** ☐ **No**

Is the medication being prescribed by, or in consultation with a cardiologist, an endocrinologist, or a physician who focuses on the treatment of disorders related to severe hypertriglyceridemia? ☐ **Yes** ☐ **No**

Will Tryngolza(olezarsen) be used in combination with Redemplo(plozasiran)? ☐ **Yes** ☐ **No**

Initial Requests:

For diagnosis of Familial chylomicronemia syndrome, please answer the following:
Does the patient have a fasting triglyceride level of at least 800 mg/dl? ☐ **Yes** ☐ **No Please submit documentation.**

Was the patient's diagnosis confirmed via molecular generic testing which demonstrated biallelic pathogenic variants in at least one gene causing familial chylomicronemia syndrome? ☐ **Yes** ☐ **No Please submit documentation.**

For diagnosis of Hypertriglyceridemia, please answer the following:
Does patient hav a fasting triglyceride level ≥500mg/dL? ☐ **Yes** ☐ **No Please submit documentation.**

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Has patient been taking at least one standard of care lipid lowering medications for at least 2 months? ☐ **Yes** ☐ **No Please submit documentation.**

Such as but not limited to:

- ☐ **statins**
- ☐ **bempedoic acid**
- ☐ **ezetimibe**
- ☐ **fibrates**
- ☐ **bile acid sequestrants**
- ☐ **icosapent**
- ☐ **PCSK9 agent**

Renewal:

Has the patient demostrated a positive clinical response with the requested medication, as evidence by a reduction reduction in serum triglyceride levels from baseline and/or a reduction in episodes of acute pancreatitis? ☐ **Yes** ☐ **No (documentation required)**

Is the medication being prescribed by, or in consultation with a cardiologist, an endocrinologist, or a physician who focuses on the treatment of disorders related to severe hypertriglyceridemia? ☐ **Yes** ☐ **No**

Is patient continuing with a very low-fat diet, less than 20 gm of fat per day? ☐ **Yes** ☐ **No**

Will Tryngolza(olezarsen) be used in combination with Redemplo(plozasiran)? ☐ **Yes** ☐ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909

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