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)

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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.****