

**Redemplo (Plozasiran) Medically Necessary
 Prior Authorization (PA) Request Form
 CT Medical Assistance Program
To Be Completed By Prescriber**

<u>Prescriber Information</u>	<u>Patient Information</u>
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Phone ()	Patient DOB:
Fax ()	Patient Primary ICD Diagnosis Code:
<u>Prescription Information</u>	
Drug Requested:	Frequency of Dosing:
☐ New therapy ☐ Continuation	Quantity Requested:

Clinical Information

Patient is 18 years of age or older?	☐ Yes ☐ No
Prescribed by or in consultation with a specialist familiar with managing FCS (e.g. lipidologist, cardiologist, gastroenterologist, endocrinologist, pancreatologist)?	☐ Yes ☐ No
Provider attests that Redemplo be used in conjunction with lifestyle modifications, including a low fat diet (< 20 g/day)?	☐ Yes ☐ No
Redemplo and Tryngolza will not be used in combination	☐ Yes ☐ No
The requested quantity does not exceed one Redemplo syringe every 3 months	☐ Yes ☐ No
Confirmation of Familial chylomicronemia syndrome (FCS) diagnosis by ONE of the following: ○ Genetic testing ○ History of fasting triglyceride level of more than 1,000 mg/dL on at least 3 occasions AND at least ONE of the following: ▪ Absent or low postheparin lipoprotein lipase activity (<20% of normal)	☐ Yes ☐ No

▪ History of acute pancreatitis not caused by alcohol or cholelithiasis ▪ Recurrent hospitalization for severe abdominal pain without other identified cause ▪ History of childhood pancreatitis ▪ Family history of hypertriglyceridemia-induced pancreatitis ○ Patient has a Moulin et al. FCS score of ≥ 10 ○ Patient has a NAFCS score ≥ 60	
<u>Continuation Requests ONLY:</u> This question should be answered only for patients who have already met the initial/above Redemplo treatment criteria and require extended therapy beyond the originally approved 1 year duration. • Provider attests that patient has experienced a continued clinical benefit and is compliant on the current therapy regimen	☐ Yes ☐ No ☐ N/A

If you answered 'NO' to any of the questions above, a Letter of Medical Necessity (LMN) must be reviewed for consideration. Please provide all relevant information relating to the medical necessity (see Conn. Gen. Stat § 17b-259b(a)) of Redemplo for this patient. Submit request, via email, to rx.lmn@ct.gov.

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that Prior Authorizations will not exceed 6 months from date of fill for controlled medications and 1 year for non-controlled medications/products, except for Early Refill Requests, which are valid one time only.

Prescriber Signature*: _____ **Date:** _____

*** Mandatory (others may not sign for prescriber). In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**

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