

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

| <b><u>Prescriber Information</u></b>                                       | <b><u>Patient Information</u></b>   |
|----------------------------------------------------------------------------|-------------------------------------|
| Prescriber's NPI:                                                          | Patient's Medicaid ID Number:       |
| Prescriber Name:                                                           | Patient Name:                       |
| Phone (        )                                                           | Patient DOB:                        |
| Fax (        )                                                             | Patient Primary ICD Diagnosis Code: |
| <b><u>Prescription Information</u></b>                                     |                                     |
| Drug Requested:                                                            | Frequency of Dosing:                |
| <input type="checkbox"/> New therapy <input type="checkbox"/> Continuation | Quantity Requested:                 |

**Clinical Information**

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| Patient is 18 years of age or older?                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Prescribed by or in consultation with a specialist familiar with managing FCS or sHTG (e.g. lipidologist, cardiologist, gastroenterologist, endocrinologist, pancreatologist)?                                                                                                                                                                                                                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Provider attests that Tryngolza be used in conjunction with lifestyle modifications, including a low fat diet (< 20 g/day for a diagnosis of FCS)?                                                                                                                                                                                                                                                                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tryngolza and Redemplo will not be used in combination                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| The requested quantity does not exceed one Tryngolza autoinjector once monthly                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diagnosis of <b>ONE</b> of the following: <ul style="list-style-type: none"> <li>• Familial chylomicronemia syndrome (FCS) confirmed by genetic testing</li> <li>• Severe hypertriglyceridemia (sHTG) (triglyceride level of <math>\geq 500</math> mg/dL) <b>AND</b> <ul style="list-style-type: none"> <li>○ Patient is on standard of care lipid lowering therapy with sub-optimal therapeutic response</li> </ul> </li> </ul> | <input type="checkbox"/> Yes <input type="checkbox"/> No |

|                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| <p><b><u>Continuation Requests ONLY:</u></b> This question should be answered only for patients who have already met the initial/above Tryngolza treatment criteria and require extended therapy beyond the originally approved 1 year duration.</p> <ul style="list-style-type: none"> <li>• Provider attests that patient has experienced a continued clinical benefit and is compliant on the current therapy regimen</li> </ul> | <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><input type="checkbox"/> N/A</p> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|

**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 Tryngolza for this patient. Submit request, via email, to [rx.lmn@ct.gov](mailto: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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