iowa total care | Iowa Health Link Iowa HHS | Hawki Iowa HHS

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization

Olezarsen (Tryngolza)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for olezarsen (Tryngolza). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and

2. Patient has a diagnosis of familial chylomicronemia syndrome (FCS) confirmed by genetic testing, (e.g., biallelic pathogenic variants in FCS-causing genes [*LPL, GPIHBP1, APOA5, APOC2*, or *LMF1*]) (attach genetic testing results); and

3. The patient has a current fasting triglyceride level of 880 mg/dL or greater (attach current lipid panel obtained within the past 30 days); and

4. The patient will use medication in combination with a low-fat diet (≤ 20 grams of total fat per day); and

5. Is prescribed by or in consultation with a cardiologist, an endocrinologist, or a provider who specializes in lipid management.

If the criteria for coverage are met, initial requests will be given for 6 months. Requests for continuation of therapy will be considered at 12-month intervals under the following conditions:

1. **Documentation of a decrease in fasting triglyceride level from baseline (attach current lipid panel obtained within the past 30 days); and**
2. **Patient continues to use medication in combination with a low-fat diet (≤ 20 grams of total fat per day); and**
3. **Is prescribed by or in consultation with a cardiologist, an endocrinologist, or a provider who specializes in lipid management.**

Non-Preferred

☐ Tryngolza

Strength	Usage Instructions	Quantity	Day's Supply
_____	_____	_____	_____

Diagnosis (attach genetic testing results): _____

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization

Olezarsen (Tryngolza)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Current Fasting triglyceride level: _____

Date obtained (attach current lipid panel obtained within the past 30 days): _____

Will patient use medication in combination with a low-fat diet (≤ 20 grams of total fat per day)?

☐ Yes ☐ No

Is prescriber a cardiologist, an endocrinologist, or a provider who specializes in lipid management?

❑ **Yes, document specialty:** _____

❑ **No** If no, note consultation with specialist:

Consultation Date:_____Physician Name, Specialty & Phone: _____

Renewal Requests

Document a decrease in fasting triglyceride level from baseline (attach current lipid panel obtained within the past 30 days).

Current fasting triglyceride level: _____ Date obtained: _____

Is patient continuing to use medication in combination with a low-fat diet (≤ 20 grams of total fat per day)?

☐ Yes ☐ No

Is prescriber a cardiologist, an endocrinologist, or a provider who specializes in lipid management?

❑ **Yes, document specialty:** _____

❑ **No** If no, note consultation with specialist:
Consultation Date:_____Physician Name, Specialty & Phone: _____

Medical or contraindication reason to override trial requirements:_____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*