

New Hampshire Medicaid Fee-for-Service Program Familial Chylomicronemia Syndrome (FCS) Criteria

Approval Date: May 12, 2026

Medications

Brand Names	Generic Names	Indication
Redempro	plozasiran	Indicated as an adjunct to diet to reduce triglycerides in adults with familial chylomicronemia syndrome (FCS)
Tryngolza	olezarsen	Indicated as an adjunct to diet to reduce triglycerides in adults with familial chylomicronemia syndrome (FCS)

Criteria for Approval

1. Patient is 18 years of age or older; **AND**
2. Patient has a diagnosis familial chylomicronemia syndrome (FCS) as confirmed by ONE of the following:
 - a. Genetic confirmation of biallelic pathogenic variants in affected genes (e.g., lipoprotein lipase [LPL], apolipoprotein [APO] A5, APOC2, lipase maturation factor 1 [LMF1], glycosylphosphatidylinositol-anchored high-density lipoprotein-binding protein 1 [GPIHBP1], glycerol-3-phosphate dehydrogenase 1 [G3PDH1]); **OR**
 - b. **All** of the following:
 - i. Fasting triglyceride (TG) levels \geq 880 mg/dL for 3 consecutive measurements; **AND**
 - ii. Secondary causes of hypertriglyceridemia have been ruled out (e.g., alcohol use, chronic kidney disease, hypothyroidism, uncontrolled diabetes, medications [e.g., atypical antipsychotics, beta-blockers, corticosteroids, oral estrogens]); **AND**
 - iii. History of pancreatitis or unexplained recurrent abdominal pain; **AND**
 - iv. No response (TG decrease $<$ 20%) to conventional lipid lowering therapies (e.g., fibrates, omega-3 fatty acids, statins, niacin, ezetimibe, proprotein convertase subtilisin/kexin type 9 [PCSK9] inhibitors); **AND**
3. Patient must **not** have hypersensitivity to any component of the product; **AND**
4. The prescriber is a cardiologist, endocrinologist, geneticist, or lipidologist, or the prescriber has consulted with a specialist in the area of the patient's diagnosis.

Initial approval period: 12 months

Criteria for Denial

Failure to meet approval criteria.

Proprietary & Confidential

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Criteria for Renewal

1. Patient must continue to meet the above criteria; **AND**
2. Patient must have disease improvement since starting medication (e.g., improvement in TG levels, absence of acute pancreatitis); **AND**
3. Patient has **not** experienced any treatment-restricting adverse effects (e.g., hyperglycemia, headache, severe hypersensitivity reactions).

Renewal approval period: 12 months

References

Available upon request.

Revision History

Reviewed by	Reason for Review	Date Approved
DUR Board	New	04/21/2026
Commissioner Designee	Approved	05/12/2026