New Hampshire Medicaid Fee-for-Service Program Tryngolza (olezarsen) Criteria

Approval Date: November 17, 2025

Medications

Brand Names	Generic Names	Indication
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 ≥ 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: 6 months

Criteria for Denial

Failure to meet approval criteria.

1. Criteria for Renewal

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

Renewal approval period: 12 months

References

Available upon request.

Revision History

Reviewed by	Reason for Review	Date Approved
DUR Board	New	09/23/2025
Commissioner designee	Approval	11/17/2025