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New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization Drug Approval Form
Tryngolza™ (olezarsen)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. Is the patient 18 years of age and older? ☐ Yes ☐ No
2. Does the patient have a diagnosis of familial chylomicronemia syndrome? **If yes, identify how diagnosis was confirmed. (Select all that apply.)** ☐ Yes ☐ No
   - ☐ Genetic confirmation of biallelic pathogenic variants in affected genes [lipoprotein lipase (LPL), apolipoprotein (APO) A5, APOC2, lipase maturation factor 1 (LMF1)]
   - ☐ Secondary causes of hypertriglyceridemia have been ruled out
   - ☐ Patient history of pancreatitis or unexplained recurrent abdominal pain
   - ☐ No response (TG decrease < 20%) to conventional lipid lowering therapies
3. Does the patient have hypersensitivity to Tryngolza™ or any excipients of the product? ☐ Yes ☐ No

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PATIENT LAST NAME:

PATIENT FIRST NAME:

4. Is the prescriber a cardiologist, endocrinologist, geneticist, or lipidologist, or has the prescriber consulted with a specialist in familial chylomicronemia syndrome? ☐ Yes ☐ No
5. Is there any additional information that would help in the decision-making process?
   If additional space is needed, please use a separate sheet.

SECTION IV: RENEWAL

1. Has the patient had clinical benefit with the use of Tryngolza™? ☐ Yes ☐ No
2. Has the patient experienced any treatment-restricting adverse effects? ☐ Yes ☐ No

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____