UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1470-1
Program	Prior Authorization/Notification
Medication	Tryngolza™ (olezarsen)
P&T Approval Date	2/2025
Effective Date	5/1/2025

1. Background:

Tryngolza™ (olezarsen) is an *APOC-III*-directed antisense oligonucleotide (ASO) indicated as an adjunct to diet to reduce triglycerides in adults with familial chylomicronemia syndrome (FCS).

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Tryngolza** will be approved based on the following criterion:

   a. Diagnosis of familial chylomicronemia syndrome (FCS) (i.e., monogenic chylomicronemia, type 1 hyperlipoproteinemia)

Authorization will be issued for 12 months

B. Reauthorization

1. **Tryngolza** will be approved based on the following criterion:

   a. Documentation of positive clinical response to Tryngolza therapy (e.g., reduction in triglycerides, reduction in episodes of acute pancreatitis)

Authorization will be issued for 12 months

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits and medical necessity may be in place.

4. References:

1. Tryngolza [package insert]. Carlsbad, CA: Ionis Pharmaceuticals, Inc.; December 2024.

Program	Prior Authorization/Notification - Tryngolza™ (olezarsen)
Change Control	
Date	Change
2/2025	New program.