Corporate Medical Policy: Familial Chylomicronemia Syndrome Therapy **"Notification"** **POLICY EFFECTIVE APRIL 1, 2026**

Restricted Product(s):

- olezarsen (Tryngolza®) subcutaneous injection for administration by a healthcare professional
- plozasiran (Redemplo®) subcutaneous injection for administration by a healthcare professional

FDA Approved Use:

- As an adjunct to diet to reduce triglycerides in adults with familial chylomicronemia syndrome (FCS)

Criteria for Medical Necessity:

The restricted product(s) may be considered medically necessary when the following criteria are met:

Initial Criteria for Approval:

1. The patient is 18 years of age or older; **AND**
2. The patient has a diagnosis of **familial chylomicronemia syndrome (FCS) [medical record documentation required]**; **AND**
3. The diagnosis has been confirmed by ONE of the following:
    a. Genetic confirmation of bi-allelic pathogenic variants in genes affecting lipoprotein lipase activity (e.g., *LPL, APOC2, APOA5, GPIHBP1, LMF1*) or low lipoprotein lipase activity (i.e., <20% of normal) **[medical record documentation required]**; **OR**
    b. North American Familial Chylomicronemia Score (NAFCS) ≥45 **[medical record documentation required]**; **OR**
    c. Documented history of fasting triglyceride (TG) levels of 880 mg/dL or higher on at least 3 separate occasions **[medical record documentation required]**; **AND**
        i. The patient has NOT had a response (TG decrease less than 20%) to conventional lipid lowering therapies (e.g., fibrates, omega-3 fatty acids, statins, niacin, ezetimibe, PCSK9 inhibitors) **[medical record documentation required]**; **AND**
        ii. ONE of the following:
            1. Documented history of recurrent episodes of acute pancreatitis (not caused by alcohol or cholelithiasis) OR recurrent hospitalizations for severe abdominal pain without other explainable cause **[medical record documentation required]**; **OR**
            2. Documented history of childhood pancreatitis **[medical record documentation required]**; **OR**
            3. Family history of hypertriglyceridemia-induced pancreatitis **[medical record documentation required]**; **AND**
4. The patient has a baseline fasting triglyceride (TG) level ≥880 mg/dL prior to initiating the requested agent **[medical record documentation required]**; **AND**

5. 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**
6. The patient will adhere to a low-fat diet (i.e., ≤ 20 grams of fat per day) **[medical record documentation required]**; **AND**
7. The patient will NOT receive the requested agent in combination with olezarsen (Tryngolza) or plozasiran (Redemplo); **AND**
8. If the request is for olezarsen (Tryngolza), ONE of the following:
    a. The patient has tried and had an inadequate response to plozasiran (Redemplo) **[medical record documentation required]**; **OR**
    b. The patient has an intolerance, FDA labeled contraindication, or hypersensitivity to plozasiran (Redemplo) **[medical record documentation required]**; **AND**
9. The patient has a physical or cognitive limitation that makes utilization of the self-administered formulation of the requested agent unsafe or otherwise not feasible, as demonstrated by BOTH of the following **[medical record documentation required]**:
    a. Inability to self-administer the medication; **AND**
    b. Lack of caregiver or support system for assistance with administration of self-administered products; **AND**
10. The prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist, endocrinologist, lipidologist, geneticist, gastroenterologist, pancreatologist) or has consulted with a specialist in the area of the patient's diagnosis; **AND**
11. The requested quantity does NOT exceed the maximum units allowed for the duration of approval (see table below); **AND**
12. For requests for injection or infusion administration of the requested medication in an **inpatient or outpatient hospital setting,** Site of Care Criteria applies (outlined below)*

    Duration of Approval: 365 days (1 year)

Continuation Criteria for Approval:

1. The patient was approved through Blue Cross NC initial criteria for approval; **OR**
2. The patient would have met initial criteria for approval at the time they started therapy; **AND**
3. The patient has demonstrated positive clinical response while using the requested agent (i.e., reduction in fasting triglycerides [TG]) **[medical record documentation required]**; **AND**
4. The patient has been adherent to a low-fat diet (i.e., ≤ 20 grams of fat per day) AND will continue to be adherent to a low-fat diet **[medical record documentation required]**; **AND**
5. The patient will NOT receive the requested agent in combination with olezarsen (Tryngolza) or plozasiran (Redemplo); **AND**
6. If the request is for olezarsen (Tryngolza), ONE of the following:
    a. The patient has tried and had an inadequate response to plozasiran (Redemplo) **[medical record documentation required]**; **OR**
    b. The patient has an intolerance, FDA labeled contraindication, or hypersensitivity to plozasiran (Redemplo) **[medical record documentation required]**; **AND**

7. The patient has a physical or cognitive limitation that makes utilization of the self-administered formulation of the requested agent unsafe or otherwise not feasible, as demonstrated by BOTH of the following **[medical record documentation required]**:
    a. Inability to self-administer the medication; **AND**
    b. Lack of caregiver or support system for assistance with administration of self-administered products; **AND**
8. The prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist, endocrinologist, lipidologist, geneticist, gastroenterologist, pancreatologist) or has consulted with a specialist in the area of the patient's diagnosis; **AND**
9. The requested quantity does NOT exceed the maximum units allowed for the duration of approval (see table below); **AND**
10. For requests for injection or infusion administration of the requested medication in an **inpatient or outpatient hospital setting,** Site of Care Criteria applies (outlined below)*

Duration of Approval: 365 days (1 year)

FDA Label Reference				
Medication	**Indication**	**Dosing**	**HCPCS**	**Maximum Units***
olezarsen (Tryngolza®) subcutaneous (SC) injection	Familial chylomicronemia syndrome (FCS)	SC: 80 mg once monthly	C9399** J3490** J3590**	960
plozasiran (Redemplo®) subcutaneous (SC) injection		SC: 25 mg every 3 months	C9399** J3490** J3590**	100

***Maximum units allowed for duration of approval**
****Non-specific assigned HCPCS codes, must submit requested product NDC**

***Site of Care Medical Necessity Criteria**

1. For requests for injection or infusion administration in an **inpatient setting**, the injection or infusion may be given if the above medical necessity criteria are met AND the inpatient admission is NOT for the sole purpose of administering the injection or infusion; **OR**
2. For requests for injection or infusion administration in an **outpatient hospital setting**, the injection or infusion may be given if the above medical necessity criteria are met AND ONE of the following must be met:

   a. History of a severe adverse event following the injection or infusion of the requested medication (i.e., anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure); **OR**
   b. Conditions that cause an increased risk for severe adverse event (i.e., unstable renal function, cardiopulmonary conditions, unstable vascular access); **OR**
   c. History of mild adverse events that have not been successfully managed through mild pre-medication (e.g., diphenhydramine, acetaminophen, steroids, fluids, etc.); **OR**
   d. Inability to physically and cognitively adhere to the treatment schedule and regimen complexity; **OR**
   e. New to therapy, defined as initial injection or infusion OR less than 3 months since initial injection or infusion; **OR**
   f. Re-initiation of therapy, defined as ONE of the following:
      i. First injection or infusion after 6 months of no injections or infusions for drugs with an approved dosing interval less than 6 months duration; **OR**
      ii. First injection or infusion after at least a 1-month gap in therapy outside of the approved dosing interval for drugs requiring every 6 months dosing duration; **OR**
   g. Requirement of a change in the requested restricted product formulation; **AND**
3. If the Site of Care Medical Necessity Criteria in #1 or #2 above are not met, the injection or infusion will be administered in a **home-based infusion** or physician office setting with or without supervision by a certified healthcare professional.

References: all information referenced is from FDA package insert unless otherwise noted below.

1. Hegele RA, Ahmad Z, Ashraf A, et al. Development and validation of clinical criteria to identify familial chylomicronemia syndrome (FCS) in North America. *J Clin Lipidol*. Published online November 12, 2024. doi:10.1016/j.jacl.2024.09.008
2. Javed F, Hegele R, Garg A, et al. Familial chylomicronemia syndrome: An expert clinical review from the National Lipid Association. *J Clin Lipidol*. 2025;19(3):382-403. doi:10.1016/j.jacl.2025.03.013

Policy Implementation/Update Information: Criteria and treatment protocols are reviewed annually by the Blue Cross NC P&T Committee, regardless of change. This policy is reviewed in Q1 annually.

April 2026: Criteria change: Added olezarsen (Tryngolza) to policy for the treatment of adults with familial chylomicronemia syndrome, as an adjunct to diet to reduce triglycerides. For Tryngolza, added to initial and continuation criteria the requirement for trial and failure of Redemplo and the requirement for use of self-administered formulation unless certain criteria are met. Removed medical record documentation requirements for specialist requirement, concomitant use statement, and verification that secondary causes have been ruled out. Added Tryngolza to SOC criteria and added associated dosing, maximum units, and HCPCS codes C9399, J3490, and J3590 to FDA label reference table. Changed policy name to “Familial Chylomicronemia Syndrome Therapy” from “Plozasiran (Redemplo®)”. **Policy notification given 1/1/2026 for effective date 4/1/2026**.

December 2025: Original medical policy criteria issued.