

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1470-2
Program	Prior Authorization/Notification
Medication	Tryngolza® (olezarsen)
P&T Approval Date	2/2025, 2/2026
Effective Date	5/1/2026

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 **both** of the following criteria:

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

-AND-

- b. Not used in combination with Redemplo (plozasiran)

Authorization will be issued for 12 months

B. Reauthorization

1. **Tryngolza** will be approved based on **both** of the following criteria:

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

-AND-

- b. Not used in combination with Redemplo (plozasiran)

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.; September 2025.

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Change Control	
Date	Change
2/2025	New program.
2/2026	Annual review. Added combination use criteria. Updated reference.