Original Effective Date: 07/17/2025
Current Effective Date: 03/13/2026
Last P&T Approval/Version: 01/28/2026
Next Review Due By: 01/2027
Policy Number: C29395-A

Tryngolza (olezarsen)

PRODUCTS AFFECTED

Tryngolza (olezarsen)

COVERAGE POLICY

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:
Familial chylomicronemia syndrome (FCS)

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by-case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

A. FAMILIAL CHYLOMICRONEMIA SYNDROME (FCS):
1. Documented diagnosis of Familial Chylomicronemia Syndrome (FCS)
   AND
2. Documentation of ONE of the following [DOCUMENTATION REQUIRED]:
   (a) Diagnosis confirmed by genetic testing (variants in LPL, apoC-II, GPIHBP1, apoA-V, apoC-II, or LMF1)
   OR
   (b) Laboratory documentation of member's current fasting triglyceride > 10 mmol/L or 880 mg/dL AND member is refractory to standard triglyceride therapy including taking stable doses of statins, omega-3 fatty acids, fibrates, or other lipid-lowering medications
   AND
3. Documentation of prescriber baseline disease activity, evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal (e.g., frequency of acute pancreatitis, idiopathic abdominal pain, xanthomas, lipemia retinalis, hepatosplenomegaly, etc.)
   AND
4. Laboratory documentation of fasting triglyceride level at baseline

CONTINUATION OF THERAPY:

A. FAMILIAL CHYLOMICRONEMIA SYNDROME (FCS):
1. Adherence to therapy at least 85% of the time as verified by the prescriber or member medication fill history OR adherence less than 85% of the time due to the need for surgery or treatment of an infection, causing temporary discontinuation.
   AND
2. Documentation of positive response to therapy as indicated by decrease in triglyceride level OR achievement of individual triglyceride patient goal OR disease stability or improvement of clinical signs and symptoms (e.g., frequency of acute pancreatitis, idiopathic abdominal pain, eruptive xanthomas, lipemia retinalis, hepatosplenomegaly, etc.).
   AND
3. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity.

DURATION OF APPROVAL:

Initial authorization: 12 months, Continuation of Therapy: 12 months

PRESCRIBER REQUIREMENTS:

Prescribed by a lipidologist, endocrinologist, cardiologist, gastroenterologist, or pancreatologist

AGE RESTRICTIONS:

18 years of age and older

QUANTITY:

80mg/ 0.8mL once every 4 weeks

PLACE OF ADMINISTRATION:

The recommendation is that injectable medications in this policy will be for pharmacy benefit coverage and patient self-administered.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:
Subcutaneous

DRUG CLASS:
Lipoprotein Lipase Deficiency (LPLD) Deficiency Agents

FDA-APPROVED USES:
Indicated as an adjunct to diet to reduce triglycerides in adults with familial chylomicronemia syndrome (FCS).

COMPENDIAL APPROVED OFF-LABELED USES:
None

APPENDIX

APPENDIX:
None

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
Familial chylomicronemia syndrome (FCS), also known as Type I hyperlipoproteinemia, is an ultra-rare autosomal recessive disorder characterized by severe hypertriglyceridemia with pediatric onset. FCS primarily results from a deficiency or absence of lipoprotein lipase (LPL), the key enzyme responsible for hydrolyzing chylomicrons—lipid-rich particles that transport triglycerides. Clinically, FCS manifests with recurrent episodes of nausea, vomiting, eruptive xanthomas, lipemia retinalis, hepatosplenomegaly, and severe abdominal pain, often causing acute pancreatitis.
The primary treatment goal in FCS is to lower triglyceride levels and mitigate symptoms, ultimately reducing the risk of acute pancreatitis. Conventional lipid-lowering agents, including statins, fibrates, and omega-3 fatty acids, offer limited efficacy in FCS, as they do not address the underlying LPL dysfunction. As a result, strict dietary fat restriction (<20 g/day) remains a cornerstone of management.
Until the approval of Tryngolza (olezarsen), there were no FDA-approved therapies specifically for FCS. Olezarsen, an RNA-targeted therapy, reduces plasma triglyceride levels by inhibiting the production of apolipoprotein C-III, a key regulator of triglyceride metabolism. Its approval was based on the pivotal BALANCE trial, a Phase 3, randomized, placebo-controlled, double-blind study evaluating its efficacy in patients with genetically confirmed FCS and fasting triglyceride levels ≥880 mg/dL. In the trial, 66 patients were randomized to receive Tryngolza 50 mg (n=21), Tryngolza 80 mg (n=22), or placebo (n=23), administered via subcutaneous injection every four weeks for 49 weeks. At six months, Tryngolza demonstrated a significant triglyceride reduction, with a mean treatment difference of –42.5% (95% CI: – 74.1, –10.9) compared to placebo. Regarding safety, the most frequently reported adverse events included injection site reactions, decreased platelet count, and arthralgia, with hypersensitivity reactions being the leading cause of treatment discontinuation.
Olezarsen offers the first targeted pharmacologic intervention for this rare condition.

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of Tryngolza (olezarsen) are considered experimental/investigational and therefore, will follow Molina's Off- Label policy. Contraindications to Tryngolza (olezarsen) include: a history of serious hypersensitivity reactions to olezarsen or any of the excipients in Tryngolza.

Exclusions/Discontinuation:
Members with documentation of platelet count > 100,000/mm should be excluded from the use of Tryngolza due to risk of thrombocytopenia reported in associated clinical trial.

OTHER SPECIAL CONSIDERATIONS:
If scheduled dose is missed, administer as soon as possible, and resume monthly dosing interval from the date of the most recently administered dose.
Use in addition to dietary management of FCS, including low fat diet of <20g of fat per day.

CODING/BILLING INFORMATION

CODING DISCLAIMER. *Codes listed in this policy are for reference purposes only and may not be all-inclusive or applicable for every state or line of business. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry-standard coding practices for all submissions. Molina has the right to reject/deny the claim and recover claim payment(s) if it is determined it is not billed appropriately or not a covered benefit. Molina reserves the right to revise this policy as needed.*

HCPCS CODE	DESCRIPTION
NA	

AVAILABLE DOSAGE FORMS:
Tryngolza SOAJ 80MG/0.8ML single-dose autoinjector

REFERENCES

1. Tryngolza (olezarsen) injection, for subcutaneous use [prescribing information] Carlsbad, CA: Ionis Pharmaceuticals; September 2025.
2. Stroes, E. S. G., Alexander, V. J., Karwatowska-Prokopczuk, E., Hegele, R. A., Arca, M., Ballantyne, C. M., Soran, H., Prohaska, T. A., Xia, S., Ginsberg, H. N., Witztum, J. L., Tsimikas, S., & Balance Investigators (2024). Olezarsen, Acute Pancreatitis, and Familial Chylomicronemia Syndrome. The New England journal of medicine, 390(19), 1781–1792. https://doi.org/10.1056/NEJMoa2400201
3. Davidson, M., Stevenson, M., Hsieh, A., Ahmad, Z., Roeters van Lennep, J., Crowson, C., & Witztum,
J. L. (2018). The burden of familial chylomicronemia syndrome: Results from the global IN-

FOCUS study. Journal of Clinical Lipidology, 12(4), 898-907.e2. https://doi.org/10.1016/j.jacl.2018.04.009
4. Familial Chylomicronemia Syndrome (FCS). (n.d.). Retrieved February 10, 2025, from https://pro.aace.com/sites/default/files/2019-02/FCS_082318_formatted.pdf

SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Duration of Approval Other Special Considerations References	Q1 2026
NEW CRITERIA CREATION	Q2 2025