



2/20/2026

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Tryngolza - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.  
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.  
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.

When conditions are met, we will authorize the coverage of Tryngolza - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Tryngolza (olezarsen)

Quantity

Frequency

Strength

Route of Administration

Expected Length of Therapy

Patient Information

Patient Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Patient Group No.: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient Phone: \_\_\_\_\_

Prescribing Physician

Physician Name: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Physician Fax: \_\_\_\_\_

Physician Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD Code: \_\_\_\_\_

Comments: \_\_\_\_\_

Please circle the appropriate answer for each question.

1. Is the requested medication being prescribed for any indications or uses that are not Food and Drug Administration (FDA)-approved, or guideline-supported?

Y  N

[If yes, no further questions.]

2. Is the patient less than 18 years of age (pediatric)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
3. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
[If no, skip to question 5.]	
4. Is there documentation showing that the patient has had a positive response to treatment, evidenced by a reduction in triglyceride levels from baseline?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[No further questions.]	
5. Is there documentation confirming a diagnosis of familial chylomicronemia syndrome (FCS), supported by genetic testing that identifies biallelic pathogenic variants in FCS-causing genes (i.e., LPL, GPIHBP1, APOA5, APOC2, or LMF1)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
6. Is there documentation of a laboratory test showing that the patient has a fasting triglyceride levels greater than or equal to 1,000 mg/dL?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
7. Is the patient currently following a very low-fat diet with less than or equal to 20 grams of fat per day, and will continue this diet while on the requested therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

<b>Prescriber (Or Authorized) Signature and Date</b>