TRICARE Prior Authorization Request Form for
olezarsen sodium (Tryngolza)

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100
Hanover, MD 21076

Fax completed form and applicable progress notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by a cardiologist, an endocrinologist, or an internal medicine physician experienced in treating disorders related to severe hypertriglyceridemia?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis?	☐ Familial Chylomicronemia Syndrome (FCS) – Proceed to question **4** ☐ Evidence of symptomatic persistent chylomicronemia with recurrent pancreatitis - Proceed to question **5** ☐ Other diagnosis – **STOP – Coverage not approved**	
4. Has the patient undergone genetic testing to confirm the diagnosis of familial chylomicronemia syndrome (FCS)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a fasting triglyceride level of 880 mg/dL or greater?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Will the patient adhere to a low fat-diet (LESS THAN OR EQUAL TO 20 g fat per day) while receiving the requested medication?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Has the patient tried and failed therapy with plozasiran (Redemplo)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[15 July 2026]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: