

## APOLIPOPROTEIN C-III (APOC3) Inhibitors

### **Goal(s):**

- Promote use of APOC3 Inhibitors that is consistent with medical literature.
- Promote use of high value products.

### **Length of Authorization:**

Up to 12 months

### **Requires PA:**

- Olezarsen (Tryngolza)
- Plozasiran (Redemplo)

### **Covered Alternatives:**

- Current PMPDP preferred drug list per OAR 410-121-0030 at [www.orpdl.org](http://www.orpdl.org)
- Searchable site for Oregon FFS Drug Class listed at [www.orpdl.org/drugs/](http://www.orpdl.org/drugs/)

| Approval Criteria   |   |   |
|---|---|---|
| 1. Is this a request for renewal of a previously approved prior authorization?  | <b>Yes:</b> Go to <b>Renewal Criteria</b>                                     | <b>No:</b> Go to #2                                   |
| 2. What diagnosis is being treated?   | Record ICD10 code. Go to #3   |   |
| 3. Is the medication prescribed by or in consultation with a specialist in familial chylomicronemia syndrome (FCS)?   | <b>Yes:</b> Go to #4  | <b>No:</b> Pass to RPh. Deny; medical appropriateness |
| 4. Does the patient have a diagnosis of familial chylomicronemia syndrome (FCS), confirmed by genetic testing?<br><br>Please submit a copy of the genetic testing results | <b>Yes:</b> Go to #5  | <b>No:</b> Go to #7                                   |
| 5. Does the patient have a current triglyceride level of 885 mg/dl or greater within the previous 6 months?   | <b>Yes:</b> Go to #6<br><br><b>Recent TG Level</b> _____<br><b>Date</b> _____ | <b>No:</b> Pass to RPh. Deny; medical appropriateness |
| 6. Does the patient agree to adhere to a low-fat diet ( $\leq$ 20 g of fat per day)?  | <b>Yes:</b> Approve for 6 months  | <b>No:</b> Pass to RPh. Deny; medical appropriateness |
| 7. Is the request for an FDA-approved indication?   | <b>Yes:</b> Go to #8  | <b>No:</b> Pass to RPh. Deny; medical appropriateness |

## Approval Criteria

|  |   |   |
|--|---|---|
| 8. Does the patient have clinically diagnosed severe hypertriglyceridemia with triglyceride levels $\geq$ 500 mg/dL within the previous 6 months?                                      | <b>Yes:</b> Go to #9<br><b>Recent TG Level</b> _____<br><b>Date</b> _____ | <b>No:</b> Pass to RPh. Deny; medical appropriateness |
| 9. Has the patient failed to have adequate benefit with, or have a contraindication to, an adequate trial (at least 8 weeks) of a fibric acid derivative (fenofibrate or gemfibrozil)? | <b>Yes:</b> Approve for 6 months  | <b>No:</b> Pass to RPh. Deny; medical appropriateness |

## Renewal Criteria

|   |   |   |
|---|---|---|
| 1. Is there documentation of a positive clinical response (i.e. clinically meaningful reduction in triglyceride level or reduction in episodes of acute pancreatitis) within the previous 6 months? | <b>Yes:</b> Approve for up to 12 months | <b>No:</b> Pass to RPh. Deny; medical appropriateness |
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