PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Familial Chylomicronemia Syndrome Preferred Specialty Management Policy
- Redemplo® (plozasiran subcutaneous injection – Arrowhead)
- Tryngolza™ (olezarsen subcutaneous injection – Ionis)

REVIEW DATE: 04/29/2026; selected revision 07/15/2026

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Redemplo and Tryngolza are both indicated as an adjunct to diet **to reduce triglycerides (TGs) in familial chylomicronemia syndrome (FCS) in adults**.[1,2] Tryngolza is also indicated to reduce TGs and the risk of acute pancreatitis in adults with severe hypertriglyceridemia (sHTG [TGs ≥ 500 mg/dL]).[2] Redemplo is an apolipoprotein C-III (apoC-III)-directed small interfering ribonucleic acid (siRNA), whereas Tryngolza is an apo-C-III-directed oligonucleotide (ASO).

POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of the Preferred Product. For all medications (Preferred and Non-Preferred), the patient is required to meet the respective standard *Prior*

Authorization Policy criteria. The program also directs the patient to try the Preferred Product for at least 1 year, unless not tolerated prior to the approval of a Non-Preferred Product. Requests for the Non-Preferred Product will also be reviewed using the exception criteria (below). All approvals are provided for 1 year. If the patient meets the standard *Hypertriglyceridemia – Redemplo Prior Authorization Policy* criteria, but has not tried the Preferred Product, a review will be offered for the Preferred Product using the respective standard *Prior Authorization Policy* criteria.

Documentation: Documentation is required for previous use of the preferred drug(s) as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information.

Preferred Products: Tryngolza
Non-Preferred Products: Redemplo

***Familial Chylomicronemia Syndrome Preferred Specialty Management Policy* non-preferred product(s) is(are) covered as medically necessary when the following non-preferred product exception criteria is(are) met. Any other exception is considered not medically necessary.**

NON-PREFERRED PRODUCT EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Redemplo	**1.** Approve for 1 year if the patient meets BOTH of the following (A and B): **A)** Patient meets the standard *Hypertriglyceridemia – Redemplo Prior Authorization (PA)* criteria; AND **B)** Patient meets ONE of the following criteria (i or ii): **i.** Patient has received Tryngolza for ≥ 1 year, unless not tolerated **[documentation required]**; OR **ii.** According to the prescriber, the patient has thrombocytopenia or is at risk for thrombocytopenia. **2.** If the patient has met the standard *Hypertriglyceridemia – Redemplo PA Policy* criteria, but has not met exception criteria (1B) offer to review for the Preferred Product using the standard *Hypertriglyceridemia – Tryngolza PA Policy* criteria.

REFERENCES

1. Redemplo® subcutaneous injection [prescribing information]. Pasadena, CA: Arrowhead; November 2025.
2. Tryngolza™ subcutaneous injection [prescribing information]. Carlsbad, CA: Ionis; January 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	04/29/2026
Selected Revision	In the Policy Statement and Exception criteria, reference to the *Familial Chylomicronemia Syndrome – Redemplo PA* and *Familial Chylomicronemia Syndrome – Tryngolza PA* was changed to *Hypertriglyceridemia – Redemplo PA* and *Hypertriglyceridemia – Tryngolza PA*.	07/15/2026