MEDICAL MUTUAL®

Drug Policy

Policy:	**20260501**	**Initial Effective Date: 5/21/2026**
Code(s):	**HCPCS J3490, J3590 or J9999**	**Annual Review Date: 5/21/2026**
SUBJECT:	**Redemplo® (plozasiran subcutaneous injection – Arrowhead)**	**Last Revised Date: 5/21/2026**

Prior approval is required for some or all procedure codes listed in this Corporate Drug Policy.

OVERVIEW

Redemplo, an apolipoprotein C-III (apoC-III)-directed small interfering ribonucleic acid (siRNA), is indicated as an adjunct to diet to reduce triglycerides (TGs) for familial chylomicronemia syndrome (FCS) in adults.[1] It is recommended to maintain a low-fat diet (≤ 20 grams of fat per day) in conjunction with Redemplo.

POLICY STATEMENT

This policy involves the use of Redemplo. Prior authorization is recommended for pharmacy and medical benefit coverage of Redemplo. Approval is recommended for those who meet the conditions of coverage in the **Criteria, Dosing, Initial/Extended Approval, Duration of Therapy**, and **Labs/Diagnostics** for the diagnosis provided. **Waste Management** applies for all covered conditions that are administered by a healthcare professional. **Conditions Not Recommended for Approval** are listed following the recommended authorization criteria and Waste Management section. Requests for uses not listed in this policy will be reviewed for evidence of efficacy and for medical necessity on a case-by-case basis.

Because of the specialized skills required for evaluation and diagnosis of patients treated with Redemplo as well as the monitoring required for AEs and long-term efficacy, initial approval requires Redemplo be prescribed by or in consultation with a physician who specializes in the condition being treated. All approvals for initial therapy are provided for the initial approval duration noted below; if reauthorization is allowed, a response to therapy is required for continuation of therapy unless otherwise noted below.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Redemplo is recommended in those who meet the following criteria:

1. **Familial Chylomicronemia Syndrome.** Approve for 1 year if the patient meets ALL of the following (A, B, C, D, E, and F):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has a fasting triglyceride level ≥ 880 mg/dL at baseline*; AND

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Note: This refers to baseline prior to treatment with a triglyceride-lowering medication. Examples of triglyceride-lowering medications include statins, niacin, fibrates, and omega-3 fatty acids.

C) Patient meets at least ONE of the following (i, ii, or iii):
- **i.** Molecular genetic test results demonstrate biallelic pathogenic variants in at least one gene causing familial chylomicronemia syndrome*; OR
  Note: Examples of genes causing Familial Chylomicronemia Syndrome include lipoprotein lipase (*LPL*), glycosylphosphatidylinositol-anchored high-density lipoprotein-binding protein 1 (*GPIHBP1*), apolipoprotein A-V (*APOA5*), apolipoprotein C-II (*APOC2*), or lipase maturation factor 1 (*LMF1*).
- **ii.** Molecular genetic test results are inconclusive, and the patient has ONE of the following* (a or b); OR
  - **a)** Patient has a Moulin familial chylomicronemia syndrome score ≥ 10; OR
  - **b)** Patient has a North American familial chylomicronemia syndrome score ≥ 45; OR
- **iii.** Patient has received a clinical diagnosis of familial chylomicronemia syndrome based on the presence of ALL of the following (a, b, and c):
  - **a)** Patient meets ONE of the following ([1] or [2]):
    - **(1)** History of acute pancreatitis not caused by alcohol or cholelithiasis; OR
    - **(2)** History of recurrent hospitalizations for severe abdominal pain without other explainable cause; AND
  - **b)** Absence of secondary hypertriglyceridemia (e.g., obesity, uncontrolled diabetes); AND
  - **c)** Lack of response to a traditional triglyceride-lowering medication; AND
    Note: Examples of triglyceride-lowering medications include statins, niacin, fibrates, and omega-3 fatty acids.

D) The medication will be used concomitantly with a low-fat diet of less than 10% of calories from fat; AND

E) Medication is prescribed by a cardiologist, an endocrinologist, a lipidologist, or a physician who focuses in the treatment of disorders related to severe hypertriglyceridemia; AND

F) Patient meets ONE of the following criteria (i or ii):
- **i.** Patient has received Tryngolza for ≥ 1 year, unless not tolerated*; OR
- **ii.** According to the prescriber, the patient has thrombocytopenia or is at risk for thrombocytopenia.

Patient currently receiving Redemplo: Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):

A) Patient is ≥ 18 years of age; AND

B) The patient has demonstrated a positive clinical response with the requested medication*; AND
Note: Examples of response to therapy include reduction in triglyceride level from baseline, reduction in episodes of acute pancreatitis.

C) The medication will be used concomitantly with a low-fat diet of less than 10% of calories from fat; AND

D) Medication is prescribed by a cardiologist, an endocrinologist, lipidologist, or a physician who focuses on the treatment of disorders related to severe hypertriglyceridemia.

Dosing in Redemplo. *Dosing must meet the following (medical benefit only):*
- The recommended dosage of REDEMPLO is 25 mg injected subcutaneously once every 3 months.

Initial Approval/ Extended Approval.
A) *Initial Approval:* 1 year
B) *Extended Approval:* 1 year

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Duration of Therapy in Redemplo: Indefinite

Labs/Diagnostics.

- Increase in Glucose: Mean increases from baseline in HbA1c (up to 0.36%) and fasting glucose (up to 9 mg/dL) were observed over time in the 25 mg REDEMPLO group. The incidence of hyperglycemia (defined as adverse events consistent with diabetes mellitus or hyperglycemia, new antidiabetic medication, or laboratory values) was higher in 25 mg REDEMPLO-treated patients without a medical history of diabetes at baseline (40%) compared to placebo-treated patients (20%).
- Increase in Liver Enzymes: Increases from baseline liver enzymes within the normal range were observed with plozasiran treatment in the FCS population. These increases occurred within the first 3 months of treatment and stabilized.
- Increase in LDL-cholesterol: Increases in low-density lipoprotein cholesterol (LDL-C) and total apolipoprotein B (apoB) were observed in the FCS population treated with REDEMPLO compared to those treated with placebo [see Clinical Studies (14)]. Despite increases in the LDL-C, the average LDL-C value at Month 12 was less than 50 mg/dL in the 25 mg REDEMPLO group.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Redemplo has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions. (Note: This is not an exhaustive list of Conditions Not Recommended for Approval).

1. **Hypertriglyceridemia (in the absence of a confirmed diagnosis of familial chylomicronemia syndrome).** A trial evaluated Redemplo in patients with severe hypertriglyceridemia.[7] However, Redemplo is not FDA-approved for this use.[1]

2. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

***Documentation Requirements:**

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

REFERENCES

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2. Javed F, Saadatagah S, Larouche M, Naderian M, et al. Recognition and management of persistent chylomicronemia: a Joint Expert Clinical Consensus by the National Lipid Association and the American Society for Preventative Cardiology. *J Clin Lipidol*. 2025;19:723-736.
3. Moulin P, Dufour R, Averna M, et al. Identification and diagnosis of patients with familial chylomicronemia syndrome (FCS): expert panel recommendations and proposal of an "FCS score". *Atherosclerosis*. 2018;275:265-272.
4. Hegele RA, Ahmad Z, Ashraf A, et al. Development and validation of clinical criteria to identify familial chylomicronemia syndrome (FCS) in North America. *J Clin Lipidol*. 2025;19(1):83-94.
5. Tryngolza® subcutaneous injection [prescribing information]. Carlsbad, CA: Ionis; January 2025.
6. Watts GF, Rosenson RS, Hegele RA, et al, for the PALISADE Study Group. Plozasiran for managing persistent chylomicronemia and pancreatic risk. *N Engl J Med*. 2025;392(2):127-137.
7. Gaudet D, Pall D, Watts GF, et al. Plozasiran (ARO-APOC3) for severe hypertriglyceridemia: The SHASTA-2 randomized clinical trial. *JAMA Cardiol*. 2024;9(7):620-630.

FOR MEDICAL BENEFIT COVERAGE REQUESTS:

Prior approval is required for HCPCS Codes J3490 and J3590 or J9999

†When *unclassified drugs* (J3490) or *unclassified biologics* (J3590) or *unclassified antineoplastics* (J9999) is determined to be Redemplo

Edits and Denials:

Prior approval: Prior approval is required for Redemplo **(HCPCS Codes J3490 , J3590, J9999)**. Requests for prior approval will be authorized by a nurse reviewer if submitted documentation meets criteria outlined within the Corporate Medical Policy.

Requests for prior approval will be forwarded to a qualified physician reviewer if submitted documentation does not meet criteria outlined within Corporate Medical Policy.

TOPPS: Claims received with **HCPCS Codes J3490, J3590, J9999** will pend with **Remark Code M3M or M4M** and will be adjudicated in accordance with the Corporate Medical Policy.

Liability: A participating provider will be required to write off charges denied as not medically necessary.

HCPCS Code(s):	
J3490	Unclassified drugs
J3590	Unclassified biologics
J9999	Unclassified antineoplastics

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