Preemptive policy: This is a P&T approved policy and can be used after the drug is FDA approved until it is superseded by an updated policy

CENTENE® Corporation

Clinical Policy: Plozasiran (ARO-APOC3)

Reference Number: CP.PHAR.721
Effective Date: FDA Approval Date
Last Review Date: 05.25
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Plozasiran (ARO-APOC3®/™) is an *APOC-III*-directed small interfering ribonucleic acid (RNAi).

FDA Approved Indication(s) [Pending]

ARO-APOC3 is indicated for the treatment as an adjunct to diet in adults with familial chylomicronemia syndrome (FCS).

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that ARO-APOC3 is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria*

**Criteria will mirror the clinical information from the prescribing information once FDA-approved*

A. Familial Chylomicronemia Syndrome (must meet all)**:**

1. Diagnosis of FCS as evidenced by all of the following (a, b, and c):*
   a. Fasting triglycerides ≥ 880 mg/dL or ≥ 10 mmol/L (lab must be dated within 90 days);
   b. One of the following (i, ii, iii, or iv, *see Appendix D*):
      i. Genetic testing confirms the presence a loss-of-function mutation in a FCS-causing gene (e.g., LPL, APOC2, APOA5, GPIHBP1, LMF1);
      ii. History of pancreatitis;
      iii. Family history of hypertriglyceridemia;
      iv. History of recurrent abdominal pain without other explainable cause;
   c. Documentation of nonresponse to both of the following (i and ii), at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated:
      i. Fibrates (e.g., fenofibric acid, fenofibrate, fenofibrate micronized, gemfibrozil);
      ii. Omega-3 fatty acids (e.g., omega-3-acid-ethyl esters, icosapent ethyl);
2. Prescribed by or in consultation with an endocrinologist, lipid specialist, or cardiologist;

3. Age ≥ 18 years;*
4. ARO-APOC3 is not prescribed concurrently with Tryngolza™;
5. Dose does not exceed 50 mg every 3 months.*

Approval duration:
Medicaid/HIM – 6 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy*

**Criteria will mirror the clinical information from the prescribing information once FDA-approved*

A. Familial Chylomicronemia Syndrome (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B)*;
2. Member is responding positively to therapy as evidenced by reduction in fasting triglycerides from baseline;
3. If request is for a dose increase, new dose does not exceed 50 mg every 3 months.*

Approval duration:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business:

CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

APOC2: apolipoprotein C-II
APOC3: apolipoprotein C-III
APOA5: apolipoprotein C-VI
FCS: familial chylomicronemia syndrome
FDA: Food and Drug Administration
GPIHBP1: glycosylphosphatidylinositol-anchored high-density lipoprotein-binding protein 1
LMF1: lipase maturation factor 1
LPL: lipoprotein lipase

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings [Pending]

- Contraindication(s): pending
- Boxed warning(s): pending

Appendix D: General Information

- FCS may also be referred to as lipoprotein lipase deficiency (LPLD), type 1 hyperlipoproteinemia, endogenous hypertriglyceridemia, familial fat-induced hypertriglyceridemia, familial hyperchylomicronemia, familial LPL deficiency, hyperlipidemia Type I (Fredrickson), hyperlipoproteinemia type IA, lipase D deficiency, chylomicronemia syndrome, familial chylomicronemia, hyperchylomicronemia familial, hyperlipemia idiopathic Burger-Grutz type, lipase D deficiency, or Burger-Grutz syndrome.
- FCS is caused by biallelic loss-of-function homozygous, compound heterozygous, or double heterozygous pathogenic variants in LPL, APOC2, APOA5, GPIHBP1, and/or LMF1.

- A specific diagnosis of FCS can be made based on clinical characteristics. Genetic testing can be used for additional information; however, a negative genetic test does not necessarily exclude a diagnosis of FCS because not all mutations are known.
- Lipid-lowering therapy such as fibrates, niacin, and omega-3 fatty acids have little to no role in treatment of FCS as they act by either decreasing VLDL or increasing lipoprotein lipase activity. Both mechanisms will not affect the chylomicrons in FCS. Though conditions other than FCS can cause elevated triglycerides levels, hypertriglyceridemia refractory to triglycerides lowering therapy should raise suspicion of FCS.

V. Dosage and Administration [Pending]

Indication	Dosing Regimen	Maximum Dose
FCS*	50 mg SC every 3 months*	50 mg/3 months*

VI. Product Availability [Pending]

Pending

VII. References

1. Brand Name Prescribing Information.
2. Watts GF, Rosenson RS, Hegele RA, et al; PALISADE Study Group. Plozasiran for managing persistent chylomicronemia and pancreatitis risk. *N Engl J Med*. 2025 Jan 9;392(2):127-137. doi: 10.1056/NEJMoa2409368.
3. Moulin P, Dufour R, Averna M, et al. Identification and diagnosis of patients with familial chylomicronaemia syndrome (FCS): Expert panel recommendations and proposal of an "FCS score". *Atherosclerosis.* 2018 Aug;275:265-272. doi: 10.1016/j.atherosclerosis.2018.06.814.
4. Handelsman Y, Jellinger PS, Guerin CK, et al. Consensus Statement by the American Association of Clinical Endocrinologists and American College of Endocrinology on the management of dyslipidemia and prevention of cardiovascular disease algorithm - 2020 Executive Summary. *Endocr Pract.* 2020 Oct;26(10):1196-1224. doi: 10.4158/CS-2020-0490.
5. Grundy SM, Stone NJ, Bailey AL, et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the management of blood cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Circulation.* 2019 Jun 18;139(25):e1082-e1143. doi: 10.1161/CIR.0000000000000625.

Coding Implications [Pending]

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
Pending	Pending

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	02.11.25	05.25

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.