



TRYNGOLZA is the only therapy included in the 2026 ACC/AHA guideline for the treatment of FCS (Class 1 [strong] recommendation)¹

HELP GET YOUR PATIENTS OUT OF THE DANGER ZONE

The first therapy proven to **significantly reduce TGs** in adults with FCS, the most severe form of SHTG, as an adjunct to diet.²⁻⁴

ACC=American College of Cardiology; AHA=American Heart Association; SHTG=severe hypertriglyceridemia; TG=triglyceride.

INDICATION

TRYNGOLZA (olezarsen) is indicated as an adjunct to diet to reduce triglycerides in adults with familial chylomicronemia syndrome (FCS).

SELECT IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

TRYNGOLZA is contraindicated in patients with a history of serious hypersensitivity to TRYNGOLZA or any of the excipients in TRYNGOLZA. Hypersensitivity reactions requiring medical treatment have occurred.

Please see Important Safety Information throughout and full [Prescribing Information](#) for TRYNGOLZA.

FCS is an underdiagnosed genetic form of sHTG⁵⁻⁸



- FCS is caused by loss-of-function pathogenic variants in the lipoprotein lipase (*LPL*) gene and in other genes encoding proteins required for LPL activity⁹
 - LPL is an enzyme that breaks down triglycerides in chylomicrons and in very low-density lipoprotein (VLDL) particles⁹
- The lack of LPL activity leads to the accumulation of VLDL and chylomicrons, leaving individuals with severely elevated triglyceride levels consistently ≥ 880 mg/dL and an increased risk of pancreatitis¹⁰
- Patients with FCS require significant dietary restrictions—10% to 15% of calories from fat or less, plus the elimination of alcohol and added sugars—to avoid pancreatitis¹
 - This does not change on treatment: advise patients with FCS to consume ≤ 20 grams of fat per day in conjunction with TRYNGOLZA²

FCS and multifactorial chylomicronemia syndrome (MCS) are both genetic forms of sHTG characterized by fasting triglyceride levels ≥ 880 mg/dL, but there are several key features that distinguish them from each other.⁴

FCS vs MCS: critical distinctions

Clinical/genetic feature		FCS	MCS
	Triglyceride levels	Persistently ≥ 880 mg/dL ¹¹	Transiently or variable ≥ 880 mg/dL ¹¹
	Population frequency	1–13 per 1 million people ^{8,12}	Up to 4000 per 1 million people ⁷
	Genetic basis	Can be monogenic ⁸	Polygenic ⁷
	Age of onset	Often younger (childhood/adolescence) ^{4,6}	Often older (mostly adulthood) ⁴
	Body weight	Often within normal body mass index (BMI) range ⁷	Often overweight (BMI between 28 and 30 kg/m ²) ⁷
	Secondary factors	Less likely (except pregnancy/hormonal birth control) ¹¹	Likely (metabolic syndrome) ¹¹
	Response to pharmacologic treatment	Minimal to no effect (fibrates, niacin, omega-3 fatty acids, and statins) ¹³	Variable response (omega-3 fatty acids and niacin) ¹³

FCS's rarity and symptom overlap with MCS make it difficult to diagnose¹⁴



Genetic testing and clinical scoring can support diagnosis.

Consider using validated scoring criteria to aid in a clinical diagnosis or to support a diagnosis of FCS with either indeterminate or positive genetic test results.^{11,14} Please note that not all genetic variants associated with FCS have been identified. So even with indeterminate results, genetic testing can be supportive of a clinical FCS diagnosis.¹¹



Click to use the [interactive clinical scoring tools](#).

FCS clinical scoring tools are available to support diagnosis, particularly for patients with indeterminate genetic test results:

- **The North American FCS (NAFCS) Score:** Developed in 2024 and validated specifically in North American patients¹⁴
- **Clinical criteria developed by Moulin et al:** A panel of European experts developed an algorithm-based diagnostic tool that was published in 2018¹¹

While clinical scoring tools are available, genetic testing continues to be an important option to support FCS diagnosis,¹¹ and some payers may require genetic test results.

TRYNGOLZA was evaluated in 45 adults with FCS in the *Balance* trial: a randomized, placebo-controlled, double-blind, phase 3 clinical trial^{2,3}



Participants were randomized to receive TRYNGOLZA or placebo once every 4 weeks for 6 months* for the primary analysis, and were continued over a 12-month[†] treatment period^{2,15}

Criteria for the trial included:

- ✓ Fasting triglyceride levels ≥ 880 mg/dL²
- ✓ Genetically identified FCS based on variants in genes known to cause complete or partial deficiency in LPL function.[‡] Participants with indeterminate genetic test results were confirmed to have FCS through adjudication by subject matter expert^{2,3,15}
- ✓ ≥ 4 -week run-in period where patients followed a low-fat diet of ≤ 20 grams of fat per day²

Primary endpoint:

- ✓ Mean percent change in fasting triglycerides from baseline to Month 6* compared with placebo²

Select secondary endpoint:

- ✓ Mean percent change in fasting triglycerides from baseline to Month 12 compared with placebo^{3,15}
- ✓ Adjudicated pancreatitis events and number of participants affected during treatment period^{3,15}

*Average of Weeks 23, 25, and 27.²

[†]Average of Weeks 51 and 53.¹⁵

[‡]Variants were *LPL*, *APOA5*, *GPIHBP1*, *LMF1*, or *APOC2*.³

APOA5=apolipoprotein A5; *APOC2*=apolipoprotein C2; *GPIHBP1*=glycosylphosphatidylinositol-anchored high-density lipoprotein binding protein 1; *LMF1*=lipase maturation factor 1.

SELECT IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Hypersensitivity Reactions

Hypersensitivity reactions (including symptoms of bronchospasm, diffuse erythema, facial swelling, urticaria, chills, and myalgias) have been reported in patients treated with TRYNGOLZA. Advise patients on the signs and symptoms of hypersensitivity reactions and instruct patients to promptly seek medical attention and discontinue use of TRYNGOLZA if hypersensitivity reactions occur.

Please see Important Safety Information throughout and full [Prescribing Information](#) for TRYNGOLZA.

Participant demographic and baseline characteristics were generally similar across treatment groups^{2§}



Participants were generally representative of the FCS population.³

Across all treatment groups, most participants were on stable background lipid-lowering therapy, such as statins, omega-3 fatty acids, and fibrates^{2,3}

Baseline characteristic	TRYNGOLZA 80 mg (n=22)	Placebo (n=23)
Body mass index (kg/m ² ; mean±SD)	25.1±6.0	24.2±4.1
History of acute pancreatitis in the prior 10 years	17 (77%)	15 (65%)
Type 1 or 2 diabetes	7 (32%)	6 (26%)
Hypertension	4 (18%)	6 (26%)
Triglyceride level (mean±SD)	2613±1499	2596±1256
apoC-III level (mean±SD)	27.5±11.6	27.7±11.7
Non-HDL cholesterol level (mean±SD)	262.9±100.4	271.3±113.3

[§]Abbreviated baseline characteristics table.³

apoC-III=apolipoprotein C-III; non-HDL=non-high-density lipoprotein; SD=standard deviation.

Please see Important Safety Information throughout and full [Prescribing Information](#) for TRYNGOLZA.

TRYNGOLZA 80 mg demonstrated significant TG reduction and numerically lower incidence of AP vs placebo²



Primary endpoint²

↓ 43%
at Month 6*

**significant mean change in
fasting triglycerides compared
with placebo**
(95% CI: -74, -11; $P=0.0084$)^{‡§}

Select secondary endpoint^{2,16}

↓ 57%
at Month 12[†]

**mean change in fasting
triglycerides compared with
placebo**
(95% CI: -103, -11)^{‡§}

Select secondary endpoint^{2,15}

~95%
AP free at 12 months

21 of 22 (95%) patients treated
with TRYNGOLZA **did not**
experience acute pancreatitis
(AP) vs 16 of 23 (70%) with
placebo over 12 months^{||¶}

TRYNGOLZA is the only therapy included in the ACC/AHA guideline for the treatment of FCS¹

The 2026 ACC/AHA Guideline on the Management of Dyslipidemia includes a Class 1 (strong) recommendation for TRYNGOLZA 80 mg for adults with FCS and fasting triglycerides ≥ 1000 mg/dL (11.3 mmol/L), as an adjunct to diet, to lower triglyceride levels and reduce risk of pancreatitis.¹

SELECT IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Liver Enzyme Abnormalities

TRYNGOLZA can cause increases in liver enzymes and hepatic fat in adults. Increases in liver enzymes were more frequently reported with the 80 mg dose as compared with the 50 mg dose. Consider liver enzyme testing before TRYNGOLZA initiation and when clinically indicated thereafter. If persistent elevations in liver enzymes occur, consider dose interruption. If serious hepatic injury with clinical symptoms and/or hyperbilirubinemia or jaundice occurs, promptly discontinue TRYNGOLZA.

Please see Important Safety Information throughout and full [Prescribing Information](#) for TRYNGOLZA.

TRYNGOLZA demonstrated a well-tolerated safety profile in the *Balance* study²



The safety of TRYNGOLZA was evaluated in 43 study participants who received at least 1 dose of treatment and in 23 participants who received placebo.^{2#}

- Mean platelet counts remained within normal limits during the study, and no patient treated with TRYNGOLZA with FCS had a platelet count <25,000/mm³. There were no major bleeding events associated with a low platelet count^{2,3}
- Adverse reactions led to discontinuation of treatment in 3 patients (7%) treated with TRYNGOLZA and 0% of patients treated with placebo. Two patients in the 80 mg TRYNGOLZA arm and 1 in the 50 mg TRYNGOLZA arm reported adverse events (diarrhea, vomiting, chest discomfort, chills, myalgia, trismus, and flushing) that led to treatment discontinuation^{2,3}

Adverse reactions** that occurred in >5% of patients treated with TRYNGOLZA and at >3% higher frequency than placebo^{2#}

	Total TRYNGOLZA (n=43)	Placebo (n=23)
Injection-site reactions	8 (19%)	2 (9%)
Decreased platelet count	5 (12%)	1 (4%)
Arthralgia	4 (9%)	0

*Average of Weeks 23, 25, and 27.²

†Average of Weeks 51 and 53.¹⁵

‡Difference from baseline mean fasting triglyceride levels of 2604 mg/dL.²

§Missing data were imputed using placebo washout imputation. The 95% CIs of treatment differences were calculated using a robust variance estimator.²

||Adjudication based on Atlanta classification; if serum lipase and/or amylase activity was less than 3 times the upper limit of normal, imaging (preferably contrast-enhanced computed tomography) was considered to confirm the diagnosis of acute pancreatitis.¹⁵

*All patients had a history of pancreatitis within 10 years prior to screening.²

‡The safety of TRYNGOLZA was evaluated in 66 patients with FCS enrolled in the *Balance* trial. In this trial, 43 patients received at least 1 dose of TRYNGOLZA, 50 mg (n=21) or 80 mg (n=22), and 23 patients received placebo. TRYNGOLZA 50 mg is not an approved dosing regimen for FCS.²

**Grouped terms composed of several similar items.²

Please see Important Safety Information throughout and full [Prescribing Information](#) for TRYNGOLZA.

Beyond the *Balance* trial: proven results and real-patient experiences with TRYNGOLZA



Case physician: Eliot Brinton, MD, FAHA, FNLA, FACE President, The Utah Lipid Center, Salt Lake City, UT
Paid consultant for Ionis Pharmaceuticals, Inc.

Patient summary *(based on an actual patient)*

57-year-old woman diagnosed with chylomicronemia at 3 months of age. Her condition was characterized by recurrent abdominal pain, eruptive xanthomas, and over 25 hospitalizations for AP. Despite adherence to a strict low-fat diet and numerous lipid-lowering therapies, her fasting TG levels were consistently extremely elevated, even exceeding 6000 mg/dL at the highest levels.

FCS diagnosis: Confirmed FCS in 2024 via clinical criteria developed by Moulin et al (NAFCS Score not yet available)¹¹

- Score: 15 (≥ 10 = "very likely FCS")¹¹



Comorbidities:

Chronic kidney disease, hypertension, hypothyroidism, intermittent transaminase elevations (now resolved), depression



Prior therapies:

Atorvastatin, rosuvastatin, ezetimibe, pioglitazone, niacin, and fenofibrate; all with minimal response



TRYNGOLZA treatment:

Initiated January 2025 (80 mg once monthly) subcutaneous injection via a self-administered autoinjector²

Results from treatment with TRYNGOLZA



Within 3 months, fasting TG levels declined to <1000 mg/dL and remained stable. Since starting therapy, the patient has not reported any AP episodes or any adverse events to her treating physician to date.

Fasting TG levels (mg/dL)*

Baseline	Month 1	Month 3	Month 4	Month 7
2479	1068	652	1943	828

- **0 AP episodes reported to date since initiating TRYNGOLZA**

*Normal range <150 mg/dL.¹⁷



Patient perspective:

Eager to initiate treatment with TRYNGOLZA after years of multiple AP attacks, she found the TRYNGOLZA autoinjector easy to use and was grateful for the consistent monthly home deliveries of TRYNGOLZA.



Physician perspective:

"After decades of suffering, she finally has consistent control over her triglycerides. When I wrote her first prescription for TRYNGOLZA the day after it was approved, she was in tears, truly grateful for the possibility of stability."

TRYNGOLZA has the potential to achieve rapid and sustained triglyceride reduction in a patient with refractory FCS and a long history of acute pancreatitis.

Click to see how TRYNGOLZA has helped other [patients with FCS](#).

This is an individual case presented from clinical practice. Individual results may vary.

SELECT IMPORTANT SAFETY INFORMATION ADVERSE REACTIONS

Most common adverse reactions in patients with FCS (incidence >5% of TRYNGOLZA-treated patients and >3% higher frequency than placebo) were injection site reactions, decreased platelet count, and arthralgia.

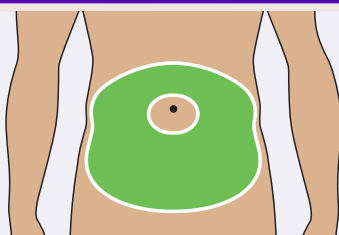
Please see Important Safety Information throughout and full [Prescribing Information](#) for TRYNGOLZA.

TRYNGOLZA is a monthly subcutaneous injection delivered via a convenient autoinjector^{2,18}



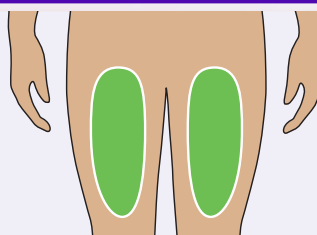
The recommended dosage of TRYNGOLZA is 80 mg once monthly with a low-fat diet of ≤ 20 grams fat per day.²

TRYNGOLZA is self-administered once monthly into 1 of the following locations²:



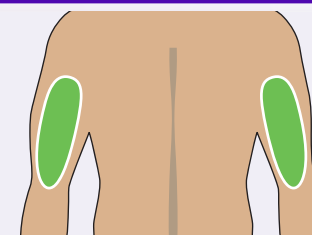
Abdomen

Appropriate for self-injection



Front of the thigh

Appropriate for self-injection



Back of the upper arm

If a healthcare professional or caregiver administers the injection

• **If a dose is missed**, it should be administered as soon as possible after the missed dose. Resume dosing at monthly intervals from the date of the most recently administered dose²

Prior to initiation, train patients and/or caregivers on proper preparation and administration.

Click for full details on administration and storage, or see the Instructions for Use and the injection training video at [TRYNGOLZAHCP.com](https://www.tryngolza.com/TRYNGOLZAHCP.com).

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Getting patients started on TRYNGOLZA



TRYNGOLZA can be prescribed using 1 of 2 options:

Electronically through your EHR



e-Prescribe TRYNGOLZA through your electronic health record (EHR) system to an in-network pharmacy*

OR

Fax the completed Start Form



Download the **TRYNGOLZA Start Form** or use the **Tear Pad** from your Account Specialist, then fax the completed form to an in-network pharmacy*

- All pharmacies in our network can contact patients to coordinate delivery and provide injection training, initiate prior authorization requests through CoverMyMeds or fax, connect eligible patients with coverage and affordability programs, and ship prescriptions through free home delivery
- See the last page for pharmacy contact information and common payer/pharmacy benefit manager affiliations

Click to access the TRYNGOLZA Start Form and other resources to help your patients get started.



Ionis Every Step™ is committed to helping your patients access TRYNGOLZA. For more information, call 1-844-789-8744, Monday to Friday, 8 AM to 8 PM ET.

*Confirm if use of a specific specialty pharmacy is required by the patient's health insurance plan.

Please see Important Safety Information throughout and full [Prescribing Information](#) for TRYNGOLZA.

FDA approved since 2024

TRYNGOLZA is the first therapy proven to significantly reduce triglyceride levels in adults with FCS when used as an adjunct to diet²



TRYNGOLZA is available through a select pharmacy network

Use of a specific pharmacy may be required by some insurance plans or pharmacy benefit managers (PBMs), so it is important to confirm with the patient's plan prior to sending the prescription.

Pharmacy	Phone number	Fax number	Website	Common payer/ PBM affiliations
Accredo	1-844-516-3319	1-888-302-1028	accredo.com/prescribers	Cigna, Express Scripts, Prime Therapeutics
BlinkRx	1-844-926-2480	1-866-585-4631	blinkrx.com/providers	Independent health plans
CVS Specialty	1-800-237-2767	1-800-323-2445	cvsspecialty.com	Aetna, CVS Health
Optum Specialty Pharmacy	1-855-427-4682	1-877-342-4596	specialty.optumrx.com	Optum Rx, UnitedHealthcare

Learn more about helping your patients get out of the danger zone at TRYNGOLZAHCP.com.

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References: 1. Blumenthal RS, Morris PB, Gaudino M, et al. 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APHA/ASPC/NLA/PCNA guideline on the management of dyslipidemia: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *J Am Coll Cardiol*. 2026;S0735-1097(25)10254-4. 2. TRYNGOLZA. Prescribing information. Ionis Pharmaceuticals. 3. Stroes ESG, Alexander VJ, Karwatowska-Prokopczuk E, et al; Balance Investigators. Olezarsen, acute pancreatitis, and familial chylomicronemia syndrome. *N Engl J Med*. 2024;390(19):1781-1792. 4. D'Erasmus L, Di Costanzo A, Cassandra F, et al. Spectrum of mutations and long-term clinical outcomes in genetic chylomicronemia syndromes. *Arterioscler Thromb Vasc Biol*. 2019;39(12):2531-2541. 5. Baass A, Paquette M, Bernard S, Hegele RA. Familial chylomicronemia syndrome: an under-recognized cause of severe hypertriglyceridaemia. *J Intern Med*. 2020;287(4):340-348. 6. Davidson M, Stevenson M, Hsieh A, et al. The burden of familial chylomicronemia syndrome: results from the global IN-FOCUS study. *J Clin Lipidol*. 2018;12(4):898-907.e2. 7. Paquette M, Bernard S. The evolving story of multifactorial chylomicronemia syndrome. *Front Cardiovasc Med*. 2022;9:886266. 8. Pallazola VA, Sajja A, Derenbecker R, et al. Prevalence of familial chylomicronemia syndrome in a quaternary care center. *Eur J Prev Cardiol*. 2020;27(19):2276-2278. 9. 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 Preventive Cardiology. *J Clin Lipidol*. 2025;19(4):723-736. 10. Javed F, Hegele RA, Garg A, et al. Familial chylomicronemia syndrome: an expert clinical review from the National Lipid Association. *J Clin Lipidol*. 2025;19(3):382-403. 11. 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. 12. O'Dea LSL, MacDougall J, Alexander VJ, et al. Differentiating familial chylomicronemia syndrome from multifactorial severe hypertriglyceridemia by clinical profiles. *J Endocr Soc*. 2019;3(12):2397-2410. 13. Brahm AJ, Hegele RA. Chylomicronaemia—current diagnosis and future therapies. *Nat Rev Endocrinol*. 2015;11(6):352-362. 14. 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. 15. Stroes ESG, Alexander VJ, Karwatowska-Prokopczuk E, et al; Balance Investigators. Olezarsen, acute pancreatitis, and familial chylomicronemia syndrome. *N Engl J Med*. 2024;390(19)(supplementary appendix):1781-1792. 16. Data on file. REF-01848. Ionis Pharmaceuticals; 2024. 17. Skulas-Ray AC, Wilson PWF, Harris WS, et al. Omega-3 fatty acids for the management of hypertriglyceridemia: a science advisory from the American Heart Association. *Circulation*. 2019;140(12):e673-e691. 18. Data on file. REF-01291. Ionis Pharmaceuticals; 2024.

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