

Anmodning om vurdering av legemiddel i Nye metoder

Skjema for leverandører

En leverandør som ønsker offentlig finansiering av et legemiddel/legemiddelindikasjon i den norske spesialisthelsetjenesten, skal anmode om vurdering i Nye metoder ved å fylle ut dette skjemaet.

Utfylt anmodningsskjema sendes til Nye metoder: nyemetoder@helse-sorost.no

Leverandøren skal på anmodningstidspunktet både ha et forslag til type helseøkonomisk analyse og en plan for når de leverer dokumentasjonen. Merk at dokumentasjon i henhold til oppdraget fra Bestillerforum for nye metoder må leveres inn senest 12 måneder etter anmodningstidspunktet.

Hele anmodningsskjemaet skal fylles ut. Mer informasjon og veiledning finnes i artikkelen [For leverandører \(nyemetoder.no\)](https://nyemetoder.no/leverandorer)

Merk: Skjemaet vil bli publisert i sin helhet på nyemetoder.no.

Innsender er klar over at skjemaet vil bli publisert i sin helhet (må krysses av): ☒

Fyll ut dato for innsending av skjema: 22.10.2026

1 Kontaktopplysninger	
1.1 Leverandør (innehaver/søker av markedsføringstillatelse i Norge)	Swedish Orphan Biovitrum AB (publ)
1.2 Navn kontaktperson	Ebba Gregory
1.3 Stilling kontaktperson	Associate Director Patient Access, Nordics & Baltics
1.4 Telefon	+46 (0)73 364 7278
1.5 E-post	Ebba.Gregory@sobi.com
Ekstern representasjon - vedlegg fullmakt	
1.6 Navn/virksomhet	Klikk eller trykk her for å skrive inn tekst.
1.7 Telefon og e-post	Klikk eller trykk her for å skrive inn tekst.

2 Legemiddelinformasjon og indikasjon	
2.1 Hva gjelder anmodningen? <i>Kryss av for hva anmodningen gjelder</i>	Et nytt virkestoff ☐ En indikasjonsutvidelse / ny indikasjon ☒ En ny styrke eller formulering ☐
2.2 Hvilken indikasjon gjelder anmodningen?	Tryngolza® er indisert som et supplement til diet i kombinasjon med annen lipidsenkande behandling, for behandling av voksne pasienter med alvorleg hypertriglyseridemi (sHTG, faste-triglyseridnivå på ≥ 880

<i>Indikasjonen skal oppgis på norsk. Hvis prosess for godkjenning pågår, oppgi også indikasjon på engelsk.</i> <i>Merk: Leverandør skal anmode om vurdering av hele indikasjonen som de har fått godkjent eller søker om godkjenning for. Dersom leverandør foreslår en avgrensning til undergrupper, må dette begrunnes og leverandør må levere dokumentasjonen som trengs for å foreta en vurdering av undergruppen i tillegg til dokumentasjonen for hele indikasjonen.</i>	mg/dL [≥ 10 mmol/L]). Tryngolza® is indicated as an adjunct to diet, in combination with other lipid-lowering therapies, for the treatment of adult patients with severe hypertriglyceridemia (sHTG, fasting triglyceride levels of ≥ 880 mg/dL [≥ 10 mmol/L]).
2.3 Handelsnavn	Tryngolza®
2.4 Generisk navn/virkestoff	Olezarsen
2.5 ATC-kode	C10AX
2.6 Administrasjonsform og styrke <i>Oppgi også forventet dosering og behandlingslengde</i> <i>Skriv kort</i>	The recommended dose of olezarsen is 80 mg administered by subcutaneous injection once monthly. Treatment with Tryngolza® is expected to start in the adulthood and is assumed to be lifelong in the model. If no response is observed after 6 months of treatment, the discontinuation of Tryngolza® should be considered on an individual basis by the prescribing physician.
2.7 Farmakoterapeutisk gruppe og virkningsmekanisme. <i>Skriv kort</i>	Pharmacotherapeutic group: lipid modifying agents, other lipid modifying agents. Mechanism of action: Olezarsen is an ASO-GalNAc3 conjugate that binds to apoC-III mRNA leading to mRNA degradation and resulting in a reduction of serum apoC-III protein. Reduction of apoC-III protein leads to increased clearance of plasma TGs and very low-density lipoproteins (VLDL).

3 Historikk – virkestoff og indikasjon	
3.1 Har Nye metoder behandlet metoder med det aktuelle virkestoffet tidligere? <i>Hvis ja, oppgi ID-nummer til metoden/metodene i Nye metoder</i>	Ja ☒ Nei ☐ ID-nummer: ID2026_014

3.2 Er du kjent med om andre legemidler/virkestoff er vurdert i Nye metoder til samme indikasjon? <i>Hvis ja, oppgi ID-nummer til metoden/metodene i Nye metoder</i>	Ja ☐ Nei ☒ ID-nummer: Klikk eller trykk her for å skrive inn tekst.
3.3 Er du kjent med om det er gjennomført en metodevurdering i et annet land som kan være relevant i norsk sammenheng? <i>Hvis ja, oppgi referanse</i>	Ja ☐ Nei ☒ Referanse: Klikk eller trykk her for å skrive inn tekst.

4 Status for markedsføringstillatelse (MT) og markedsføring	
4.1 Har legemiddelet MT i Norge for en eller flere indikasjoner? <i>Hvis ja - skriv inn dato for norsk MT for den første indikasjonen</i>	Ja ☒ Nei ☐ Dato for MT for første indikasjon: 17.09.2025
4.2 Markedsføres legemiddelet i Norge?	Ja ☐ Nei ☒
4.3 Har legemiddelet MT i Norge for anmodet indikasjon? <i>For alle metoder: Fyll ut prosedyrenummer i EMA (det europeiske legemiddelbyrået)</i> <i>Hvis metoden ikke har MT i Norge, fyll ut forventet tidspunkt (måned/år) for CHMP opinion i EMA.</i> <i>Hvis metoden har MT i Norge, fyll ut dato for MT</i>	MT i Norge: Ja ☐ Nei ☒ Prosedyrenummer i EMA: EMA/VR/0000336189 Hvis metoden ikke har MT: Forventet tidspunkt for CHMP opinion i EMA (måned/år): CHMP granted October 15, 2026 Forventet tidspunkt for markedsføringstillatelse (MT) for den aktuelle indikasjonen i Norge (måned/år): December 2026 Hvis metoden har MT: Dato for MT i Norge for den aktuelle indikasjonen: Klikk eller trykk for å skrive inn en dato.
4.4 Har legemiddelet en betinget markedsføringstillatelse for anmodet indikasjon?	Ja ☐ Nei ☒ Beskrivelse: Klikk eller trykk her for å skrive inn tekst.

<i>Hvis ja, fyll ut en beskrivelse av hva som skal leveres til EMA og når.</i>	
4.5 Har anmodet indikasjon vært i «accelerated assessment» hos EMA?	Ja ☐ Nei ☒
4.6 Har legemiddelet «orphan drug designation» i EMA?	Ja ☐ Nei ☒
<i>Hvis ja, fyll ut dato</i>	Dato for «orphan drug designation»: Not for this indication

5 Ordning for forenklet vurdering av PD-(L)1-legemidler	
5.1 Er legemiddelet registrert i Nye metoders ordning «Forenklet vurdering av PD-(L)1-legemidler»?	Ja ☐ Nei ☒

6 Sammenlignbarhet og anbud	
6.1 Finnes det andre legemidler med lignende virkningsmekanisme og /eller tilsvarende effekt til den aktuelle indikasjonen?	Ja ☐ Nei ☒ Kommentar: Klikk eller trykk her for å skrive inn tekst.
6.2 Vurderer leverandør at legemiddelet i anmodningen er sammenlignbart med et eller flere andre legemidler som Nye metoder har besluttet å innføre til den samme indikasjonen? <i>Hvis ja, hvilke(t)? Oppgi ID-nummer på metoden/metodene i Nye metoder</i>	Ja ☐ Nei ☒ Legemiddel og ID-nummer: Klikk eller trykk her for å skrive inn tekst.
6.3 Er det eksisterende anbud på terapiområdet som kan være aktuelt for legemiddelet?	Ja ☐ Nei ☒ Kommentar: Klikk eller trykk her for å skrive inn tekst.

7 Nordisk samarbeid JNHB (Joint Nordic HTA-bodies)	
7.1 Er anmodet indikasjon aktuell for utredning i det nordiske HTA-samarbeidet JNHB?	Ja ☐ Nei ☒ Begrunnelse:
<i>Hvis nei, begrunn kort</i>	

	Tryngolza® is not a hospital medicine in Finland. Therefore, it is not suitable for a joint Nordic assessment.
--	--

8 Europeisk samarbeid om vurdering av relativ effekt og sikkerhet (HTAR)

8.1 Er anmodet legemiddel/indikasjon omfattet av regelverket for utredning av relativ effekt og sikkerhet i europeisk prosess (HTAR)? <i>Hvis ja, fyll ut dato for søknad om MT til EMA</i>	Ja ☐ Nei ☒ Dato for søknad til EMA: Klikk eller trykk for å skrive inn en dato.
--	--

9 Helseøkonomisk dokumentasjon og forslag til helseøkonomisk analyse

9.1 Hvilken type helseøkonomisk analyse foreslår leverandøren? <i>F.eks. kostnad-per-QALY analyse eller kostnadsminimeringsanalyse.</i> <i>Begrunn forslaget</i>	A cost-utility analysis using a Markov model will be used to assess the cost-effectiveness of Tryngolza® + SoC vs SoC alone. Primary outcomes of the model: QALYs, total costs, total life year, and incremental cost-effectiveness ratio (ICER).
9.2 Pasientpopulasjonen som den helseøkonomiske analysen baseres på, herunder eventuelle undergrupper.	Adult patients with severe hypertriglyceridemia (TG levels $\geq$ 880 mg/dL ($\geq$ 10 mmol/L)).
9.3 Hvilken dokumentasjon skal ligge til grunn? (H2H studie, ITC, konstruert komparatorarm etc.) <i>Angi det som er relevant med tanke på hvilken type analyse som foreslås.</i>	H2H study.
9.4 Forventet legemiddelbudsjett i det året med størst budsjettvirkning i de første fem år.	Not available yet. A budget impact analysis is planned to be submitted in the complete application.
9.5 Forventet tidspunkt (måned og år) for levering av dokumentasjon til Direktoratet for	03/2027

medisinske produkter og/eller Sykehusinnkjøp HF.	
Tidspunkt må oppgis	

10 Sykdommen og eksisterende behandling	
10.1 Sykdomsbeskrivelse for aktuell indikasjon <i>Kort beskrivelse av sykdommens patofysiologi og klinisk presentasjon / symptombilde, eventuelt inkl. referanser</i>	sHTG is a lifelong condition characterised by elevated plasma TG levels [1], with ≥ 880 mg/dL (≥ 10 mmol/L) often used as a critical threshold associated with a high risk of complications requiring urgent intervention [2]. sHTG is most often caused by a combination of secondary risk factors (including lifestyle factors such as high-fat diet, comorbidities, alcohol intake, the use of medications that increase TG levels), and a genetic susceptibility [3]. The severely elevated plasma TG levels lead to an increased risk of health complications, including progressive development of acute and chronic pancreatitis (AP, CP), diabetes mellitus, cardiovascular (CV) disease, nephropathy, and increased mortality [4, 5]. The clinical presentation of the disease varies widely, with some patients being asymptomatic [6], some experience the above-mentioned health complications, while others experience symptoms such as eruptive xanthomas (small yellow papules caused by very high blood TGs), lipemia retinalis (a milky appearance of the retinal vessels without associated visual impairment), recurrent abdominal pain without the diagnosis of AP, hepatosplenomegaly (enlargement of the liver and spleen), neuropsychiatric and cognitive complications [4]. The risk of APs increases with rising TG levels and AP is a risk factor driving mortality in patients with sHTG [4,7]. APs induced by elevated TG levels are associated with physical burden (intense pain, gastrointestinal symptoms and fatigue), as well as impaired health-related quality of life, both during and in between episodes [8]. References: 1. Ginsberg, H.N., et al., <i>Triglyceride-rich lipoproteins and their remnants: metabolic insights, role in atherosclerotic cardiovascular disease, and emerging therapeutic strategies-a consensus statement from</i>

Kommentert [MR1]: Vicky, I think we can stick to mellitus here because also Type 2 diabetes can increase with TG levels.

Kommentert [VM2R1]: Oki, I was just checking that too!

	<i>the European Atherosclerosis Society. Eur Heart J, 2021. 42(47): p. 4791–4806.</i> 2. Mach, F., et al., <i>2019 ESC/EAS Guidelines for the management of dyslipidaemias: lipid modification to reduce cardiovascular risk: The Task Force for the management of dyslipidaemias of the European Society of Cardiology (ESC) and European Atherosclerosis Society (EAS). European Heart Journal, 2020. 41(1): p. 111–188.</i> 3. Brahm, A.J. and R.A. Hegele, <i>Chylomicronaemia—current diagnosis and future therapies. Nature Reviews Endocrinology, 2015. 11(6): p. 352–362.</i> 4. Bashir, B., et al., <i>Severe Hypertriglyceridaemia and Chylomicronaemia Syndrome-Causes, Clinical Presentation, and Therapeutic Options. Metabolites, 2023. 13(5).</i> 5. Patel, R.S., et al., <i>Elevated plasma triglyceride concentration and risk of adverse clinical outcomes in 1.5 million people: a CALIBER linked electronic health record study. Cardiovascular Diabetology, 2022. 21(1): p. 102</i> 6. Bashir, B., et al., <i>Ethnic Diversity and Distinctive Features of Familial Versus Multifactorial Chylomicronemia Syndrome: Insights From the UK FCS National Registry. Arteriosclerosis, Thrombosis, and Vascular Biology, 2024. 44(11): p. 2334–2346.</i> 7. Subramanian, S., et al., <i>Prevention and treatment of hypertriglyceridemia-mediated acute pancreatitis: A narrative review. European Journal of Internal Medicine, 2026. 145: p. 106648.</i> 8. Kessler, A.S., et al., <i>A qualitative study to explore the patient experience of hypertriglyceridemia-related acute pancreatitis. J Clin Lipidol, 2025. 19(4): p. 931–941.</i>
10.2 Fagområde <i>Angi hvilket fagområde som best beskriver metoden</i>	Velg fagområde fra menyen: Endokrine sykdommer
10.3 Kreftområde <i>Hvis metoden gjelder fagområdet Kreftsykdommer, angi hvilket kreftområde som er aktuelt</i>	Velg kreftområde fra menyen: Velg et element.
10.4 Dagens behandling	The Norsk legemiddelhåndbok states that there are no established treatment guidelines for the treatment of sHTG in Norway, but notes the elevated risk of AP, and

<i>Nåværende standardbehandling i Norge, inkl. referanse</i>	the potential benefit of fibrates as a complement to a high dose omega-3-fatty acid intake [1]. International guidelines by the European Society of Cardiology (ESC)/European Atherosclerosis Society (EAS) call for mandatory action to prevent AP in patients with TG levels ≥ 880 mg/dL). They recommend a low-fat diet (10-15% of total energy), a reduction of alcohol intake as well as pharmacological therapy, including fibrates, omega-3 fatty acids and statins [2]. References 1. Retterstøl, H. and Berge, K. E. <i>Hyperlipidemi</i>. Norsk Legemiddelhåndbok, 2026. Available at: Hyperlipidemi - Norsk legemiddelhåndbok 2. Mach, F., et al., 2019 ESC/EAS Guidelines for the management of dyslipidaemias: lipid modification to reduce cardiovascular risk: The Task Force for the management of dyslipidaemias of the European Society of Cardiology (ESC) and European Atherosclerosis Society (EAS). <i>European Heart Journal</i>, 2020. 41(1): p. 111–188.
10.5 Prognose <i>Beskriv prognosen med nåværende behandlingstilbud, inkl. referanse</i>	Traditional lipid-lowering treatment, such as fibrates, omega-3 fatty acids, statins and niacin, can lower TG levels by 10-50% [1, 2]. However, they are less effective in sHTG compared to mild and moderate HTG [1]. Approximately a third of patients with sHTG continue to have TG levels ≥ 880 mg/dL over time, suggesting an inadequate response to lipid-lowering treatment as one possible reason [3]. Acute pancreatitis (AP) is the most serious and clinically significant complication of sHTG. APs due to sHTG tend to be more severe and associated with longer hospital stays and higher mortality rate than APs from other aetiologies [1]. The risk of AP increases with rising TG levels [1] and TG levels ≥ 880 mg/dL represent a critical threshold associated with a high risk of AP requiring urgent intervention [4]. AP is an important risk factor driving mortality in patients with sHTG [5]. In addition, patients with sHTG are predisposed to recurrent episodes of AP [6] and these are associated with long-term complications and progression to chronic pancreatic dysfunction [7]. Beyond AP, sHTG is associated with cardiovascular (CV) disease, diabetes mellitus, and nephropathy [1].

	APs induced by elevated TG levels are associated with humanistic burden, affecting patients both during AP episodes and in between episodes. AP episodes are associated with intense pain, gastrointestinal symptoms (nausea, vomiting, diarrhoea, bloating, heartburn) and fatigue. Other symptoms include fever, dizziness, loss of appetite, dehydration, and cognitive and mobility problems [8]. Health-related quality of life (HRQoL) is severely impaired during an AP episode caused by elevated TG levels, but also the post-recovery period is associated with substantially reduced HRQoL compared with the general population [8]. In addition, patients reported impaired ability to perform daily activities both during and in between AP episodes [8]. Patients who develop CP are at risk of further deterioration of QoL due to chronic pain and pain-related disability and unemployment [9]. 1. Bashir, B., et al., <i>Severe Hypertriglyceridaemia and Chylomicronaemia Syndrome-Causes, Clinical Presentation, and Therapeutic Options</i>. <i>Metabolites</i>, 2023. 13(5). 2. Gouni-Berthold, I., J. Schwarz, and H.K. Berthold, <i>Updates in Drug Treatment of Severe Hypertriglyceridemia</i>. <i>Curr Atheroscler Rep</i>, 2023. 25(10): p. 701–709. 3. Sikora Kessler, A., et al., <i>Temporal patterns of triglyceride testing and test results among adults with severe or extreme hypertriglyceridemia in US clinical practice</i>. <i>Am J Prev Cardiol</i>, 2025. 24: p. 101356. 4. Mach, F., et al., <i>2019 ESC/EAS Guidelines for the management of dyslipidaemias: lipid modification to reduce cardiovascular risk: The Task Force for the management of dyslipidaemias of the European Society of Cardiology (ESC) and European Atherosclerosis Society (EAS)</i>. <i>European Heart Journal</i>, 2020. 41(1): p. 111–188. 5. Subramanian, S., et al., <i>Prevention and treatment of hypertriglyceridemia-mediated acute pancreatitis: A narrative review</i>. <i>European Journal of Internal Medicine</i>, 2026. 145: p. 106648. 6. Bashir, B., et al., <i>Pancreatic and cardiometabolic complications of severe hypertriglyceridaemia</i>. <i>Curr Opin Lipidol</i>, 2024. 35(4): p. 208–218. 7. Gagyi, E.-B., et al., <i>Incidence of recurrent and chronic pancreatitis after acute pancreatitis: a systematic review and meta-analysis</i>. <i>Therapeutic</i>
--	--

	Advances in Gastroenterology, 2024. 17: p. 17562848241255303. 8. Kessler, A.S., et al., <i>A qualitative study to explore the patient experience of hypertriglyceridemia-related acute pancreatitis</i>. J Clin Lipidol, 2025. 19(4): p. 931–941. 9. Machicado, J.D., et al., <i>Quality of Life in Chronic Pancreatitis is Determined by Constant Pain, Disability/Unemployment, Current Smoking, and Associated Co-Morbidities</i>. Am J Gastroenterol, 2017. 112(4): p. 633-642.
10.6 Det nye legemiddelets innplassering i behandlingsalgoritmen	Tryngolza® is indicated as an adjunct to diet, in combination with other lipid-lowering therapies, for the treatment of adult patients with severe hypertriglyceridemia (sHTG, fasting triglyceride levels of ≥ 880 mg/dL [≥ 10 mmol/L]). Currently, there are no treatments available for this patient population, who do not have adequate response to traditional lipid-lowering therapy, in Norway. Tryngolza® is expected to be given as an addition to the dietary restrictions (low-fat diet) and the lipid-lowering treatment that these patients currently are on. Traditional triglyceride-reducing treatments such as fibrates and omega-3 show some efficacy in patients with mild-to-moderate HTG. However, in severe HTG, these treatments show less effect. In addition, they were allowed in the pivotal Phase 3 studies CORE and CORE2. Patients are expected to continue receiving these treatments together with the low-fat diet.
10.7 Pasientgrunnlag <i>Beskrivelse, insidens og prevalens av pasienter omfattet av aktuell indikasjon* i Norge, inkl. referanse.</i>	In Norway, the prevalence of sHTG (TG ≥ 880 mg/dL) has been reported to be 0.13% (95% CI 0.12–0.14) based on large population surveys [1]. sHTG were shown to be associated with a number of serious co-morbidities, such as cardiovascular disease (CVD),

Antall norske pasienter antatt aktuelle for behandling med legemiddelet til denne indikasjonen. * Hele pasientgruppen som omfattes av aktuell indikasjon skal beskrives	type 2 diabetes and AP, as well as with an imbalance of genes involved in lipid metabolism [1]. Considering a Norwegian adult population (≥ 18 years old) of 4,486,121 people in 2025 [2], we can estimate around 5,383 to 6,281 adult prevalent patients with SHTG in Norway. We were not able to identify a reliable estimate on the incidence of SHTG in Norway, or transferable data from the Nordics or Europe. Thus, we estimated an incidence rate based on the formula $\text{incidence rate} = \text{prevalence} / \text{average disease duration}$, assuming the prevalence presented above (0.13%), and estimating an average disease duration of 20 or 30 years, based on the assumption of a lifetime disease and an approximate age of 50 at diagnosis. This results in an estimate of 6.5 or 4.3 new cases per 100,000 person-years. This would thus lead to an incidence estimation of 193 to 292 patients per year, depending on a longer or shorter time estimated to be spent in ill-health. In addition, for the main submission, Sobi is in collaboration with Kjetil Retterstøl, who aims to conduct further analysis on the data from the above referenced Rettestøl 2017 article to better estimate prevalence and incidence. References: 1. Retterstøl K, Narverud I, Selmer R, et al. Severe hypertriglyceridemia in Norway: prevalence, clinical and genetic characteristics. <i>Lipids Health Dis.</i> 2017;16(1):115. Published 2017 Jun 12. doi:10.1186/s12944-017-0511-9 2. Statistics Norway. 12871: Population, by age, contents, year and gender. 2025.
---	--

11 Studiekarakteristika for relevante kliniske studier			
	Studie 1	Studie 2	Studie 3
11.1 Studie-ID Studienavn, NCT-nummer, hyperlenke	CORE-TIMI 72a (NCT05079919, Study Details NCT05079919 A Study of Olezarsen (ISIS 678354) Administered to Participants With Severe	CORE2-TIMI 72b (NCT05552326, Study Details NCT05552326 A Study of Olezarsen Administered Subcutaneously to Participants With Severe	Klikk eller trykk her for å skrive inn tekst.

	Hypertriglyceridemia ClinicalTrials.gov	Hypertriglyceridemia ClinicalTrials.gov	
11.2 Studietype og -design	Phase 3, multicenter, double-blind, randomized, placebo-controlled.	Phase 3, multicenter, double-blind, randomized, placebo-controlled.	Klikk eller trykk her for å skrive inn tekst.
11.3 Formål	To measure the efficacy and safety of olezarsen as compared with placebo in patients with SHTG.	To measure the efficacy and safety of olezarsen as compared with placebo in patients with SHTG.	Klikk eller trykk her for å skrive inn tekst.
11.4 Populasjon <i>Viktige inklusjons- og eksklusjonskriterier</i>	Adult patients with TG levels ≥ 500 mg/dL (≥ 5.6 mmol/L). Inclusion criteria consisted of patients ≥ 18 years of age with a fasting TG ≥ 500 mg/dL who were on concurrent lipid-lowering therapy adhering to standard of care, optimized and stabilized for at least 4 weeks prior to screening and who agreed to adhere to diet and lifestyle counselling during screening period and throughout the study. Key exclusion criteria were patients diagnosed with familial chylomicronemia syndrome (FCS) and active pancreatitis within 4 weeks prior to	Adult patients with TG levels ≥ 500 mg/dL (≥ 5.6 mmol/L). Inclusion criteria consisted of patients ≥ 18 years of age with a fasting TG ≥ 500 mg/dL who were on concurrent lipid-lowering therapy adhering to standard of care, optimized and stabilized for at least 4 weeks prior to screening and who agreed to adhere to diet and lifestyle counselling during screening period and throughout the study. Key exclusion criteria were patients diagnosed with familial chylomicronemia syndrome (FCS) and active pancreatitis within 4 weeks prior to	Klikk eller trykk her for å skrive inn tekst.

	screening or during the screening period.	screening or during the screening period.	
11.5 Intervensjon (n) <i>Dosering, doseringsintervall, behandlingsvarighet</i>	Olezarsen 50 mg or 80 mg administered via subcutaneous injection once every 4 weeks for 49 weeks of the 53-week treatment period, after which they underwent a 13-week post-treatment follow-up period. Alternative to the 13-week post-treatment follow-up period, patients could elect to enroll in the open-label extension (OLE) study (NCT05681351).	Olezarsen 50 mg or 80 mg administered via subcutaneous injection once every 4 weeks for 49 weeks of the 53-week treatment period, after which they underwent a 13-week post-treatment follow-up period. Alternative to the 13-week post-treatment follow-up period, patients could elect to enroll in the open-label extension (OLE) study (NCT05681351).	Klikk eller trykk her for å skrive inn tekst.
11.6 Komparator (n) <i>Dosering, doseringsintervall, behandlingsvarighet</i>	Matching placebo to olezarsen 50 mg or 80 mg administered via subcutaneous injection once every 4 weeks for 49 weeks of the 53-week treatment period, after which they underwent a 13-week post-treatment follow-up period. Alternative to the 13-week post-treatment follow-up period, patients could elect to enroll in the open-label extension (OLE) study (NCT05681351).	Matching placebo to olezarsen 50 mg or 80 mg administered via subcutaneous injection once every 4 weeks for 49 weeks of the 53-week treatment period, after which they underwent a 13-week post-treatment follow-up period. Alternative to the 13-week post-treatment follow-up period, patients could elect to enroll in the open-label extension (OLE) study (NCT05681351).	Klikk eller trykk her for å skrive inn tekst.

11.7 Endepunkter	Primary endpoint:	Primary endpoint:	Klikk eller trykk her for å skrive inn tekst.
<i>Primære, sekundære og eksplorative endepunkter, herunder definisjon, målemetode og ev. tidspunkt for måling</i>	- The percent change in fasting TG from baseline to 6 months, reported as the difference between each olezarsen dose group and pooled placebo. Secondary endpoints - The percent change in fasting TG from baseline to 12 months between olezarsen 80 mg group or olezarsen 50 mg and pooled placebo - The percent change from baseline to 6 and 12 months for fasting apoC-III between olezarsen 80 mg group or olezarsen 50 mg and pooled placebo - The percent change from baseline to 6 and 12 months for remnant cholesterol between olezarsen 80 mg group or olezarsen 50 mg and pooled placebo - The percent change from baseline to 6 and	- The percent change in fasting TG from baseline to 6 months, reported as the difference between each olezarsen dose group and pooled placebo. Secondary endpoints - The percent change in fasting TG from baseline to 12 months between olezarsen 80 mg group or olezarsen 50 mg and pooled placebo - The percent change from baseline to 6 and 12 months for fasting apoC-III between olezarsen 80 mg group or olezarsen 50 mg and pooled placebo - The percent change from baseline to 6 and 12 months for remnant cholesterol between olezarsen 80 mg group or olezarsen 50 mg and pooled placebo - The percent change from baseline to 6 and	

	12 months for non-high-density lipoprotein cholesterol (non-HDL-C) between olezarsen 80 mg group or olezarsen 50 mg and pooled placebo • The proportion of participants who achieve fasting TG < 500 mg/dL at 6 and 12 months, using combined CORE and CORE2 data • The proportion of participants who achieve fasting TG < 880 mg/dL at 6 and 12 months among those with baseline values at or above 880 mg/dL, using combined CORE and CORE2 data • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between pooled olezarsen treatment group and pooled placebo, using combined CORE and CORE2 data • Absolute change in hepatic fat fraction (HFF) from Baseline to Month 12	12 months for non-high-density lipoprotein cholesterol (non-HDL-C) between olezarsen 80 mg group or olezarsen 50 mg and pooled placebo • The proportion of participants who achieve fasting TG < 500 mg/dL at 6 and 12 months, using combined CORE and CORE2 data • The proportion of participants who achieve fasting TG < 880 mg/dL at 6 and 12 months among those with baseline values at or above 880 mg/dL, using combined CORE and CORE2 data • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between pooled olezarsen treatment group and pooled placebo, using combined CORE and CORE2 data • Absolute change in hepatic fat fraction (HFF) from Baseline to Month 12	
--	--	--	--

	between pooled olezarsen treatment group and pooled placebo in the MRI cohort, using the combined data from CORE-TIMI 72a and CORE2-TIMI 72b • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between pooled olezarsen treatment group and pooled placebo in the subgroup with baseline fasting TG $\geq$ 880 mg/dL and a prior history of pancreatitis, using the combined data from CORE-TIMI 72a and CORE2-TIMI 72b Exploratory endpoints: • Major adverse cardiovascular events • Percent change in fasting TC, LDL-C, HDL-C, apolipoprotein (apo)B, apoB-48, apoE, apoA-1, Lp(a) from Baseline at Month 6 and 12 compared to placebo • Proportion of patients who achieve fasting	between pooled olezarsen treatment group and pooled placebo in the MRI cohort, using the combined data from CORE-TIMI 72a and CORE2-TIMI 72b • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between pooled olezarsen treatment group and pooled placebo in the subgroup with baseline fasting TG $\geq$ 880 mg/dL and a prior history of pancreatitis, using the combined data from CORE-TIMI 72a and CORE2-TIMI 72b Exploratory endpoints: • Major adverse cardiovascular events • Percent change in fasting TC, LDL-C, HDL-C, apolipoprotein (apo)B, apoB-48, apoE, apoA-1, Lp(a) from Baseline at Month 6 and 12 compared to placebo • Proportion of patients who achieve fasting	
--	---	---	--

	TG < 500 mg/dL at Month 6 compared to placebo in the subgroup of patients with baseline fasting TG ≥ 500 mg/dL • Proportion of patients who achieve fasting TG < 880 mg/dL at Month 6 compared to placebo in the subgroup of patients with baseline fasting TG ≥ 880 mg/dL • Proportion of patients who achieve fasting TG < 1000 mg/dL (< 11.3 mmol/L) at Month 6 and proportion of patients who achieve fasting TG < 1000 mg/dL at Month 12 compared to placebo in the subgroup of patients with baseline TG ≥ 1000 mg/dL • Proportion of patients who achieve fasting TG < 150 mg/dL (< 1.7 mmol/L) at Month 6 and proportion of patients who achieve fasting TG < 150 mg/dL at Month 12 compared to placebo • Proportion of patients who	TG < 500 mg/dL at Month 6 compared to placebo in the subgroup of patients with baseline fasting TG ≥ 500 mg/dL • Proportion of patients who achieve fasting TG < 880 mg/dL at Month 6 compared to placebo in the subgroup of patients with baseline fasting TG ≥ 880 mg/dL • Proportion of patients who achieve fasting TG < 1000 mg/dL (< 11.3 mmol/L) at Month 6 and proportion of patients who achieve fasting TG < 1000 mg/dL at Month 12 compared to placebo in the subgroup of patients with baseline TG ≥ 1000 mg/dL • Proportion of patients who achieve fasting TG < 150 mg/dL (< 1.7 mmol/L) at Month 6 and proportion of patients who achieve fasting TG < 150 mg/dL at Month 12 compared to placebo • Proportion of patients who	
--	--	--	--

	achieve $\geq 40\%$ and $\geq 70\%$ reductions in fasting TG from Baseline at Month 6 and proportion of patients who achieve $\geq 40\%$ and $\geq 70\%$ reductions in fasting TG from Baseline at Month 12 compared to placebo (performed as a meta-analysis of both trials) - Proportion of patients who develop fasting TG > 2000 mg/dL (> 22.6 mmol/L) at Month 6 and proportion of patients who develop fasting TG > 2000 mg/dL at Month 12 compared to placebo in the subgroup of patients with baseline TG ≤ 2000 mg/dL - Homeostatic model of insulin resistance (HOMA-IR), HOMA-B, and HbA1c - Fibrosis-4 (FIB-4) index - Inflammatory and cardiometabolic biomarkers - Adjudicated acute pancreatitis	achieve $\geq 40\%$ and $\geq 70\%$ reductions in fasting TG from Baseline at Month 6 and proportion of patients who achieve $\geq 40\%$ and $\geq 70\%$ reductions in fasting TG from Baseline at Month 12 compared to placebo (performed as a meta-analysis of both trials) - Proportion of patients who develop fasting TG > 2000 mg/dL (> 22.6 mmol/L) at Month 6 and proportion of patients who develop fasting TG > 2000 mg/dL at Month 12 compared to placebo in the subgroup of patients with baseline TG ≤ 2000 mg/dL - Homeostatic model of insulin resistance (HOMA-IR), HOMA-B, and HbA1c - Fibrosis-4 (FIB-4) index - Inflammatory and cardiometabolic biomarkers - Adjudicated acute pancreatitis	
--	--	--	--

	event rate from Week 1 to Week 53 between pooled olezarsen treatment group and pooled placebo in patients with a prior history of pancreatitis within 10 years prior to Screening • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between individual olezarsen treatment group and pooled placebo • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between individual olezarsen treatment group and pooled placebo, in patients with baseline TG $\geq$ 880 mg/dL and a prior history of pancreatitis • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between individual olezarsen treatment group and pooled	event rate from Week 1 to Week 53 between pooled olezarsen treatment group and pooled placebo in patients with a prior history of pancreatitis within 10 years prior to Screening • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between individual olezarsen treatment group and pooled placebo • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between individual olezarsen treatment group and pooled placebo, in patients with baseline TG $\geq$ 880 mg/dL and a prior history of pancreatitis • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between individual olezarsen treatment group and pooled	
--	---	---	--

	placebo, in patients with a prior history of pancreatitis within 10 years prior to Screening • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between pooled olezarsen treatment group and pooled placebo • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between individual olezarsen treatment group and pooled placebo • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between pooled olezarsen treatment group and pooled placebo in patients with baseline TG $\geq$ 880 mg/dL and a prior history of pancreatitis • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between	placebo, in patients with a prior history of pancreatitis within 10 years prior to Screening • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between pooled olezarsen treatment group and pooled placebo • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between individual olezarsen treatment group and pooled placebo • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between pooled olezarsen treatment group and pooled placebo in patients with baseline TG $\geq$ 880 mg/dL and a prior history of pancreatitis • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between	
--	---	---	--

	individual olezarsen treatment groups and pooled placebo in patients with baseline TG $\geq$ 880 mg/dL and a prior history of pancreatitis • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between pooled olezarsen treatment group and pooled placebo in patients with a prior history of pancreatitis within 10 years prior to Screening • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between individual olezarsen treatment groups and pooled placebo in patients with a prior history of pancreatitis within 10 years prior to Screening • Percent change in HFF from Baseline to Month 12, as measured by MRI (performed as a meta-	individual olezarsen treatment groups and pooled placebo in patients with baseline TG $\geq$ 880 mg/dL and a prior history of pancreatitis • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between pooled olezarsen treatment group and pooled placebo in patients with a prior history of pancreatitis within 10 years prior to Screening • Adjudicated acute pancreatitis event rate from Week 1 to Week 53 between individual olezarsen treatment groups and pooled placebo in patients with a prior history of pancreatitis within 10 years prior to Screening • Percent change in HFF from Baseline to Month 12, as measured by MRI (performed as a meta-	
--	---	---	--

	analysis of both trials) - Relationship of TG polygenic risk score with baseline TG, TG lowering, and pancreatitis event rate - Health care utilization: Incidence of all-cause ER visits, all-cause hospitalizations, ER visits related to adjudicated pancreatitis, hospitalizations related to adjudicated pancreatitis, as well as total all-cause inpatient days and total inpatient days related to adjudicated pancreatitis compared to placebo - PK: Plasma trough exposure and post-treatment concentrations of olezarsen; half-life for subjects who do not rollover to the open-label extension (OLE) study - Anti-drug antibodies (ADA) over time	analysis of both trials) - Relationship of TG polygenic risk score with baseline TG, TG lowering, and pancreatitis event rate - Health care utilization: Incidence of all-cause ER visits, all-cause hospitalizations, ER visits related to adjudicated pancreatitis, hospitalizations related to adjudicated pancreatitis, as well as total all-cause inpatient days and total inpatient days related to adjudicated pancreatitis compared to placebo - PK: Plasma trough exposure and post-treatment concentrations of olezarsen; half-life for subjects who do not rollover to the open-label extension (OLE) study - Anti-drug antibodies (ADA) over time	
--	---	---	--

11.8 Relevante subgruppeanalyser <i>Beskrivelse av ev. subgruppeanalyser</i>	Primary analysis was performed by treatment group: the 80 mg and 50 mg groups. Relevant subgroup analyses were performed on patients with fasting TG levels of < 880 mg/dL and TG levels ≥ 880 mg/dL and on patients with a history of AP.	Primary analysis was performed by treatment group: the 80 mg and 50 mg groups. Relevant subgroup analyses were performed on patients with fasting TG levels of < 880 mg/dL and TG levels ≥ 880 mg/dL and on patients with a history of AP.	Klikk eller trykk her for å skrive inn tekst.
11.9 Oppfølgingstid <i>Hvis pågående studie, angi oppfølgingstid for data som forventes å være tilgjengelige for vurderingen hos Direktoratet for medisinske produkter samt den forventede/planlagte samlede oppfølgingstid for studien</i>	Patients were administered olezarsen or placebo SC once every 4 weeks for 49 weeks of the 53-week treatment period, after which they underwent a 13-week post-treatment follow-up period.	Patients were administered olezarsen or placebo SC once every 4 weeks for 49 weeks of the 53-week treatment period, after which they underwent a 13-week post-treatment follow-up period.	Klikk eller trykk her for å skrive inn tekst.
11.10 Tidsperspektiv resultater <i>Pågående eller avsluttet studie? Tilgjengelige og fremtidige datakutt</i>	Completed (2025)	Completed (2025)	Klikk eller trykk her for å skrive inn tekst.
11.11 Publikasjoner	Olezarsen for Managing Severe	Olezarsen for Managing Severe	Klikk eller trykk her for å skrive inn tekst.

<i>Tittel, forfatter, tidsskrift og årstall. Ev. forventet tidspunkt for publisering</i>	Hypertriglyceridemia and Pancreatitis Risk. Marston, N. A., et al. <i>N Engl J Med.</i> 2025 Design and Rationale of the CORE – TIMI 72a and CORE2 – TIMI 72b Trials of Olezarsen in Patients with Severe Hypertriglyceridemia. Marston, N. A., et al. <i>Am Heart J.</i> 2025	Hypertriglyceridemia and Pancreatitis Risk. Marston, N. A., et al. <i>N Engl J Med.</i> 2025 Design and Rationale of the CORE – TIMI 72a and CORE2 – TIMI 72b Trials of Olezarsen in Patients with Severe Hypertriglyceridemia. Marston, N. A., et al. <i>Am Heart J.</i> 2025	
---	--	--	--

12 Igangsatte og planlagte studier	
12.1 Er det pågående eller planlagte studier for legemiddelet innenfor samme indikasjon som kan gi ytterligere informasjon i fremtiden? <i>Hvis ja, oppgi forventet tidspunkt</i>	Ja ☒ Nei ☐ An ongoing phase 3 open-label extension study of the CORE and CORE2 studies, NCT05681351; N=800, estimated study completion: Q3 2027.
12.2 Er det pågående eller planlagte studier for legemiddelet for andre indikasjoner?	Ja ☒ Nei ☐ The ongoing phase 3 open-label study in adult patients with FCS previously treated with volanesorsen, CS7, NCT05185843, to be completed in Q4-2026 The ongoing phase 3 OLE study (an open-label extension study of the Balance study, adult patients with FCS), CS13, NCT05130450; N=60, to be completed in Q4-2026 The ongoing phase 3 open-label study in pediatric patients with FCS, CS21, NCT07727538, initiated Q2-2026

13 Diagnostikk	
13.1 Vil bruk av legemiddelet til anmodet indikasjon kreve diagnostisk test for analyse av biomarkør? <i>Hvis ja, fyll ut de neste spørsmålene</i>	Ja ☒ Nei ☐
13.2 Er testen etablert i klinisk praksis? <i>Hvis ja, testes pasientene rutinemessig i dag?</i>	Ja ☒ Nei ☐ Hvis ja, testes pasientene rutinemessig i dag? Ja ☒ Nei ☐
13.3 Hvis det er behov for en test som ikke er etablert i klinisk praksis, beskriv behovet inkludert antatte kostnader/ressursbruk	Klikk eller trykk her for å skrive inn tekst.

14 Andre relevante opplysninger	
14.1 Har dere vært i kontakt med fagpersoner (for eksempel klinikere) ved norske helseforetak om dette legemiddelet/indikasjonen? <i>Hvis ja, hvem har dere vært i kontakt med og hva har de bidratt med?</i> <i>(Relevant informasjon i forbindelse med rekruttering av fageksperter i Nye metoder)</i>	Ja ☒ Nei ☐ We have established contact with Professor Kjetil Retterstøl and will collaborate with him on an analysis to establish the incidence and prevalence rates of sHTG in Norway.
14.2 Anser leverandør at det kan være spesielle forhold ved dette legemiddelet som gjør at en innkjøpsavtale ikke kan basere seg på flat rabatt for at legemiddelet skal kunne oppfylle prioriteringskriteriene? <i>Hvis ja, begrunn kort.</i> <i>Hvis ja, skal eget skjema fylles ut og sendes til Sykehusinnkjøp HF samtidig med at dokumentasjon til metodevurdering sendes til Direktoratet for medisinske produkter.</i> Nærmere informasjon og skjema: Informasjon og opplæring - Sykehusinnkjøp HF	Ja ☐ Nei ☒ Klikk eller trykk her for å skrive inn tekst.

14.3 Andre relevante opplysninger?	We would appreciate a dialogue meeting with the DMP to discuss key topics prior to submission of our application: - Agreement on submission date and timelines. - Structure of the health economic model. We look forward to coordinating with the DMP on these points to support a high-quality and efficient evaluation process.
------------------------------------	---

Informasjon om Nye metoder finnes på nettsiden nyemetoder.no