



For patients living with
severe hypertriglyceridemia
(sHTG; TGs ≥ 500 mg/dL)

CAN MORE BE DONE?

TG=triglyceride.

Hypothetical patient cases; actor portrayals.

INDICATION

TRYNGOLZA (olezarsen) is indicated as an adjunct to diet to reduce triglycerides (TG) and the risk of acute pancreatitis in adults with severe hypertriglyceridemia (sHTG: TG ≥ 500 mg/dL).

SELECT IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

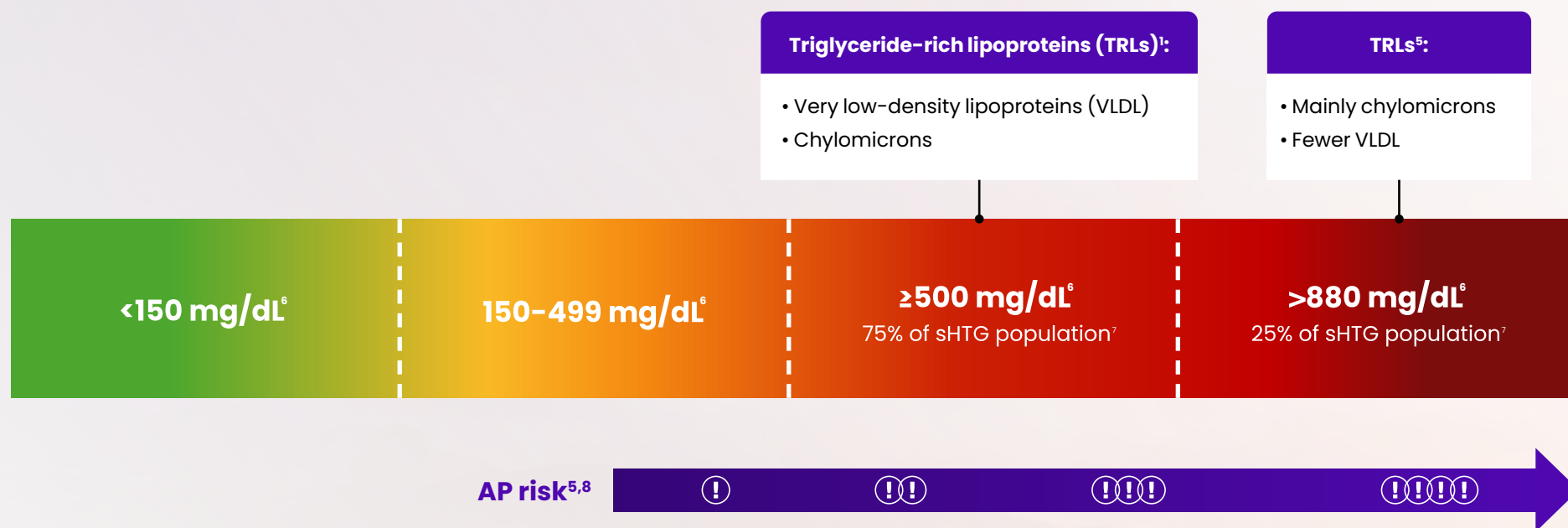
TRYNGOLZA is contraindicated in patients with a history of serious hypersensitivity to TRYNGOLZA or any of the excipients in TRYNGOLZA. Hypersensitivity reactions requiring medical treatment have occurred.

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

As triglyceride levels rise across the severe hypertriglyceridemia (sHTG) spectrum, so do the risks



Expert guidelines highlight the urgency in lowering triglyceride levels that are ≥ 500 mg/dL to reduce associated risks¹⁻⁴



Postprandial spikes can push patients into the acute pancreatitis (AP) danger zone.^{1,5,9,10}

Help get your patients out of the danger zone



Achieve significant reductions in triglycerides and a longer time to first adjudicated acute pancreatitis events in patients with severe hypertriglyceridemia (sHTG; TGs ≥ 500 mg/dL)¹¹

TRYNGOLZA: a once-monthly, self-administered autoinjector with flexible dosing¹¹

UP TO
↓ 72%

statistically significant mean change in fasting triglycerides with TRYNGOLZA 80 mg compared with placebo at Month 6* ($P < 0.0001$); primary endpoint^{11†}

[†]In CORE, TRYNGOLZA 50 mg and 80 mg demonstrated a statistically significant mean change of -63% and -72%, respectively, in fasting triglycerides from baseline to Month 6 compared with placebo ($P < 0.0001$). In CORE2, TRYNGOLZA 50 mg and 80 mg demonstrated a statistically significant mean change of -49% and -55%, respectively, in fasting triglycerides from baseline to Month 6 compared with placebo ($P < 0.0001$).¹¹

UP TO
↓ 91%

reduction in the adjudicated acute pancreatitis event rate with TRYNGOLZA 50 mg compared with placebo^{11‡}

[‡]In the integrated analysis of CORE and CORE2, TRYNGOLZA 50 mg and 80 mg demonstrated reductions of 91% (RR: 0.09; 95% CI: 0.02, 0.42) and 76% (RR: 0.24; 95% CI: 0.08, 0.69), respectively, in adjudicated acute pancreatitis event rates over 53 weeks compared with placebo. The pooled TRYNGOLZA group demonstrated an 85% reduction (RR: 0.15; 95% CI: 0.05, 0.40).¹¹

5%

of TRYNGOLZA-treated patients discontinued due to adverse reactions vs 2% of placebo-treated patients¹¹

• The most common adverse reactions (incidence $\geq 2\%$ higher than placebo) were injection-site reactions and liver enzyme increases¹¹

*Average of Weeks 25 and 27.¹¹

The efficacy and safety of TRYNGOLZA 50 mg and 80 mg were evaluated in 2 randomized, double-blind, placebo-controlled, phase 3 clinical trials (CORE and CORE2), which included 1061 adults with sHTG. The primary endpoint was mean percent change in fasting triglycerides from baseline to Month 6 compared with placebo.^{11,12}

RR=rate ratio.

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.

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Oliver, age 49

TGs >500 mg/dL and diabetes

Tryngolza[®]
(olezarsen) injection

Hypothetical patient case; actor portrayal.

Fasting triglyceride levels

(3 panels, 6 weeks apart)

- 672 mg/dL
- 774 mg/dL
- 576 mg/dL

BMI

- 29

Cardiovascular health

- Blood pressure: 132/80 mmHg
- CV history: no prior MI, stroke, or PAD
- Total cholesterol: 224 mg/dL
- High-density lipoprotein cholesterol (HDL-C): 40 mg/dL
- Low-density lipoprotein cholesterol (LDL-C): 66 mg/dL
- Non-HDL-C: 184 mg/dL

Medical history

- **Type 2 diabetes mellitus**

Current treatment regimen

- Omega-3 fatty acid, statin, and fibrate (8 years)
- Metformin to help manage type 2 diabetes (8 years)
- GLP-1 to help manage type 2 diabetes (1 year)

BMI=body mass index; CV=cardiovascular; GLP-1=glucagon-like peptide-1; MI=myocardial infarction; PAD=peripheral arterial disease; SOC=standard of care; TG=triglyceride.

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

Despite being on SOC, can more be done to lower Oliver's triglycerides?

- Oliver's **endocrinologist** added TRYNGOLZA **50 mg** to his current treatment regimen.

- After 6 months, his fasting triglycerides **were reduced 49% to 294 mg/dL.**

No adverse reactions reported to date.



Hypothetical patient case; actor portrayal.

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 or an increase in dosage and when clinically indicated thereafter. If persistent elevations in liver enzymes occur, consider dose interruption and/or dose reduction. If serious hepatic injury with clinical symptoms and/or hyperbilirubinemia or jaundice occurs, promptly discontinue TRYNGOLZA.

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Evelyn, age 59

**TGs >500 mg/dL
and prior AP**

Tryngolza[®]
(olezarsen) injection

Hypothetical patient case; actor portrayal.

**Fasting
triglyceride levels**

(3 panels, 5 weeks apart)

- 672 mg/dL
- 734 mg/dL
- 508 mg/dL

BMI

- 31

Cardiovascular health

- Blood pressure: 134/82 mmHg
- CV history: no prior MI, stroke, or PAD
- Total cholesterol: 224 mg/dL
- High-density lipoprotein cholesterol (HDL-C): 38 mg/dL
- Low-density lipoprotein cholesterol (LDL-C): 68 mg/dL
- Non-HDL-C: 176 mg/dL

Medical history

- **Acute pancreatitis episode 3 years earlier**

Current treatment regimen

- Has been on omega-3 fatty acid and fibrate for 3 years; HCP prescribes a statin following the 3 most recent lipid panels (on statin for 18 months)

AP=acute pancreatitis; BMI=body mass index; CV=cardiovascular; HCP=healthcare provider; MI=myocardial infarction; PAD=peripheral arterial disease; SOC=standard of care; TG=triglyceride.

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Despite being on SOC, can more be done to lower Evelyn's triglycerides?

- Evelyn's **cardiologist** added TRYNGOLZA **50 mg** to her current treatment regimen.
- After 3 months, her cardiologist increased to **80 mg** for additional TG reduction.
- After 6 months on **80 mg**, her fasting triglycerides **were reduced 72% to 142 mg/dL**.

Mild injection-site reactions reported.



Hypothetical patient case; actor portrayal.

SELECT IMPORTANT SAFETY INFORMATION ADVERSE REACTIONS

Most common adverse reactions in patients with sHTG (incidence $\geq 2\%$ higher than placebo) were injection site reactions and liver enzyme increases.

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Christopher, age 53

TGs >880 mg/dL

Tryngolza[®]
(olezarsen) injection

Hypothetical patient case; actor portrayal.

Fasting triglyceride levels

(3 panels, 4 weeks apart)

- 1014 mg/dL
- 892 mg/dL
- 939 mg/dL

BMI

- 34

Cardiovascular health

- Blood pressure: 138/85 mmHg
- CV history: no prior MI, stroke, or PAD
- Total cholesterol: 277 mg/dL
- High-density lipoprotein cholesterol (HDL-C): 32 mg/dL
- Low-density lipoprotein cholesterol (LDL-C): 65 mg/dL (directly measured)
- Non-HDL-C: 245 mg/dL

Medical history

- No acute pancreatitis events to date

Current treatment regimen

- On TRYNGOLZA 50 mg for 3 months; continues omega-3 fatty acid and statin therapy initiated 2 years ago; per clinical assessment, HCP determines further TG reduction is warranted

BMI=body mass index; CV=cardiovascular; HCP=healthcare provider; MI=myocardial infarction; PAD=peripheral arterial disease; TG=triglyceride.

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When might an HCP consider increasing Christopher's TRYNGOLZA dose to 80 mg for further triglyceride reduction?

- Christopher's **lipidologist** increased his current dose of TRYNGOLZA to **80 mg** to achieve further triglyceride reductions.
- After 6 months, his fasting triglycerides **were reduced 64% to 339 mg/dL.**

No adverse reactions reported to date.



Hypothetical patient case; actor portrayal.

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Getting patients started on TRYNGOLZA



Two ways to prescribe:

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*

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

TRYNGOLZA is available through a select network of pharmacies
Visit the website to learn more and to access helpful resources to get started.

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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. 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. 3. Newman CB, Blaha MJ, Boord JB, et al. Lipid management in patients with endocrine disorders: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2020;105(12):3613-3682. 4. Kirkpatrick CF, Sikand G, Petersen KS, et al. Nutrition interventions for adults with dyslipidemia: a clinical perspective from the National Lipid Association. *J Clin Lipidol*. 2023;17(4):428-451. 5. Yuan G, Al-Shali KZ, Hegele RA. Hypertriglyceridemia: its etiology, effects and treatment. *CMAJ*. 2007;176(8):1113-1120. 6. Ginsberg HN, Packard CJ, Chapman MJ, et al. Triglyceride-rich lipoproteins and their remnants: metabolic insights, role in atherosclerotic cardiovascular disease, and emerging therapeutic strategies—a consensus statement from the European Atherosclerosis Society. *Eur Heart J*. 2021;42(47):4791-4806. 7. Kessler AS, Baum SJ, Kutrieb E, et al. Healthcare utilization and expenditures among adults with severe hypertriglyceridemia in US clinical practice. Poster presented at: National Lipid Association Annual Scientific Sessions; May 29–June 1, 2025; Miami, FL. 8. Rashid N, Sharma PP, Scott RD, Lin KJ, Toth PP. Severe hypertriglyceridemia and factors associated with acute pancreatitis in an integrated health care system. *J Clin Lipidol*. 2016;10(4):880-890. 9. Keirns BH, Sciarillo CM, Koemel NA, Emerson SR. Fasting, non-fasting and postprandial triglycerides for screening cardiometabolic risk. *J Nutr Sci*. 2021;10:e75. 10. Hegele RA, Ginsberg HN, Chapman MJ, et al. The polygenic nature of hypertriglyceridaemia: implications for definition, diagnosis, and management. *Lancet Diabetes Endocrinol*. 2014;2(8):655-666. 11. TRYNGOLZA. Prescribing information. Ionis Pharmaceuticals. 12. Marston NA, Bergmark BA, Alexander VJ, et al. Olezarsen for managing severe hypertriglyceridemia and pancreatitis risk. *N Engl J Med*. 2026;394(5):429-441.

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