Missouri Pharmacy Program – Preferred Drug List

Cryopyrin-Associated Periodic Syndrome (CAPS) Agents

Effective 05/26/2010
Revised 10/04/2018

Preferred Agents	Non-Preferred Agents
• Ilaris®	• Arcalyst®

Approval Criteria

- Appropriate Diagnosis
  - Cryopryin-associated periodic syndrome (CAPS)
  - Familial Cold Autoinflammaotry Syndrome (FCAS)
  - Familial Cold Uticaria (FCU)
  - Muckle-Wells Syndrome (MWS)
  - Neonatal-Onset Multisystem Inflammatory Disease (NOMID)
- Failure to achieve desired therapeutic outcomes with trial on 1 preferred agent
  - Documented trial period for preferred agents
  - Documented ADE/ADR to preferred agents
- Documented compliance on current therapy regimen

Denial Criteria

- Lack of approval criteria
- Lack of adequate trial on required preferred agents
- Patient less than 4 years old for Ilaris therapy
- Patients less than 12 years old for Arcalyst therapy
- Concurrent Tumor Necrosis Factor (TNF) blocking agent therapy
- Drug Prior Authorization Hotline: (800) 392-8030