



Missouri Pharmacy Program – Preferred Drug List



Agents for Cryopyrin-Associated Periodic Syndrome (CAPS)

Effective 05/26/2010

Revised 01/05/2012

Preferred Agents

- Ilaris®

Non-Preferred Agents

- Arcalyst®

<u>Approval Criteria</u>	<u>Denial Criteria</u>
Appropriate Diagnosis: <ul style="list-style-type: none"> • Cryopyrin-associated periodic syndrome (CAPS) • Familial Cold Autoinflammation Syndrome (FCAS) • Familial Cold Urticaria (FCU) • Muckle-Wells Syndrome (MWS) • Neonatal-Onset Multisystem Inflammatory Disease (NOMID) 	Lack of approval criteria
Failure to achieve desired therapeutic outcomes with trial on 1 preferred agent	Lack of adequate trial on required preferred agents
Documented trial period for preferred agents	Patient less than 4 years old for Ilaris therapy
Documented ADE/ADR to preferred agents	Patients less than 12 years old for Arcalyst therapy
Documented compliance on current therapy regimen	Concurrent Tumor Necrosis Factor (TNF) blocking agent therapy
	Drug Prior Authorization Hotline: (800) 392-8030