ARCALYST (RILONACEPT)

Products Affected

- **ARCALYST**

PA Criteria	Criteria Details
Covered Uses	*Treatment of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) in adults and children 12 and older.
Exclusion Criteria	N/A
Required Medical Information	*Must be clinically diagnosed Cryopyrin-Associated Periodic Syndromes (CAPS): including Familial Cold Auto inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS).
Age Restrictions	*Must be 12 years of age or older.
Prescriber Restrictions	*Must be prescribed by an immunologist, allergist, dermatologist, rheumatologist, or neurologist that specializes in the diagnosis and treatment of the condition.
Coverage Duration	*Initial : 6 months Renewal: 12 months
Other Criteria	*Criteria for continuation of therapy: * Patient is tolerating treatment * Patient has disease stabilization or improvement in disease (as defined by standard parameters for the patient's condition) *Benefit type: Pharmacy *Adopted: 12/10/08 *Reviewed: 3/8/17: Added specialist prescriber criteria, removed review by medical director, added continuation of therapy, 4/11/18: updated continuation of therapy criteria & removed cautions.