Reference number(s)
5598-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	☑
Standard Control – Choice (SCCF)	☑
Preferred Drug Plan Design (PDPD)	☐
Advanced Control Specialty (ACSF)	☑
Advanced Control Specialty – Choice (ACSCF)	☑
Managed Medicaid Template (MMT)	☐
Marketplace (MF)	☐
Aetna Health Exchange (AHE)	☐
Aetna Individual Lives (IVL)	☐
Value (VF)	☑
New to Market (NTM)	☐

Formulary	Applies
Advanced Control Specialty Formulary Chart (ACSFC)	☐
Standard Formulary Chart (SFC)	☐
Value Formulary Chart (VFC)	☐
Medical Benefit	☐
Medical Benefit: Biosimilars First	☐
Medical Benefit: Advanced Biosimilars First	☐
Medical Benefit: Managed Medicaid (MMMB)	☐
Medical Benefit: Add-on	☐
Medicare Part B	☐
Medicare Part B: Biosimilars First	☐
Medicare Part B: Advanced Biosimilars First	☐

Exceptions Criteria
Cryopyrin-Associated Periodic Syndromes (CAPS)

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Standard Control Formulary (SF), Standard Control Choice Formulary (SCCF), Advanced Control Specialty Formulary (ACSF), Advanced Control Specialty – Choice Formulary (ACSCF), and Value Formulary (VF).

Plan Design Summary

This program applies to the cryopyrin-associated periodic syndromes (CAPS) products specified in this document. Coverage for the targeted product is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to members who are new to treatment with the targeted product for the first time.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Cryopyrin-Associated Periodic Syndromes Products

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

	Product(s)
Preferred	• Ilaris (canakinumab)
Target	• Arcalyst (rilonacept)

Exception Criteria

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

Coverage for Arcalyst is provided when either of the following criteria is met:

- Member is currently receiving treatment with Arcalyst, excluding when Arcalyst is obtained as samples or via manufacturer's patient assistance programs.
- Member has a documented inadequate response or intolerable adverse event with the preferred product Ilaris.

References

1. Arcalyst [package insert]. London, UK: Kiniksa Pharmaceuticals (UK), Ltd; May 2021.
2. Ilaris [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; August 2023.