Pharmacy Drug Policy Checklist

POLICY NAME Arcalyst (rilonacept) POLICY #

Criteria

Exclusion Criteria – Any of the following prevents coverage		
	4.1 Inadequate response to initial or previous rilonacept therapy	
	4.2 Health Alliance does not cover concurrent therapy with other immunomodulators based upon the possible increased risk for infections and other potential pharmacological interactions	
Criteria for Coverage for Cryopyrin-Associated Periodic Syndromes (CAPS)		
	1.1 Diagnosis of CAPS	
	1.2 Diagnosis must be confirmed by genetic testing demonstrating a mutation in the NLRP3 gene and presence of specific clinical criteria	
	1.3 Age 12 years or older	
	1.4 Prescribed by or in consultation with a rheumatologist (musculoskeletal doctor), geneticist (gene doctor), or allergist/immunologist (immune system doctor)	
Criteria for Coverage for Recurrent Pericarditis (long term heart inflammation)		
	2.1 Diagnosis of recurrent pericarditis as supported by ≥ 3 previous episodes	
	2.2 Age 12 years or older	
	2.3 Prescribed by or in consultation with a cardiologist (heart doctor) or rheumatologist (musculoskeletal doctor)	
	2.4 Patient is currently stable on standard of care (such as nonsteroidal anti-inflammatory drug(s) [NSAIDs], colchicine, and/or systemic corticosteroids)	

Criteria for Coverage for Deficiency of the IL-1-Receptor Antagonist (DIRA)		
	3.1 Diagnosis of deficiency of the IL-1RN (DIRA) as supported by clinical criteria	
	3.2 Diagnosis confirmed by genetic testing supported mutation in the IL1RN gene	
	3.3 Patient weighs 10kg or more	
	3.4 Prescribed by or in consultation with a rheumatologist (musculoskeletal doctor), geneticist (gene doctor), or a physician specializing in the treatment of auto-inflammatory disorders	
	3.5 All other interleukin-1 blockers have been discontinued	
Approval Time		
	5.1 Initial Authorization will be placed for 12 months	
	5.2 All subsequent authorizations will be placed for 12 months, based upon clinical response to therapy CPT Codes	