UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2023 P 1402-2
Program	Prior Authorization/Notification
Medication	Sotyktu™ (deucravacitinib)
P&T Approval Date	1/2023, 7/2023
Effective Date	10/1/2023; Oxford only: N/A

1. Background:
Sotyktu is a tyrosine kinase 2 (TYK2) inhibitor indicated for the treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

Limitations of Use:
Not recommended for use in combination with other potent immunosuppressants.

2. Coverage Criteria[a]:

A. Plaque Psoriasis

1. **Initial Authorization**

a. **Sotyktu** will be approved based on **both** of the following criteria:

(1) Diagnosis of moderate-to-severe plaque psoriasis

-AND-

(2) Patient is not receiving Sotyktu in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Sotyktu** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Sotyktu therapy

-AND-

(2) Patient is not receiving Sotyktu in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx

(secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits and/or Medical Necessity may be in place.

4. Reference:

1. Sotyktu [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; September 2022

Program	Prior Authorization/Notification - Sotyktu (deucravacitinib)
Change Control	
1/2023	New program
7/2023	Updated not receiving in combination language to targeted immunomodulator and updated examples.