Mass General Brigham
Health Plan

Sotyktu (deucravacitinib)
Effective 01/01/2024

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693		
	Non-Specialty Medications All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	N/A		

Overview
Sotyktu (deucravacitinib) is approved for the treatment of adult patients with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

Coverage Guidelines
Authorization may be granted for members who are new to the plan currently receiving treatment with Sotyktu, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted for members when all the following criteria are met, and documentation is provided:

1. The patient is 18 years of age or older
2. The member has a diagnosis of moderate to severe plaque psoriasis
3. At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
4. Paid claims or physician documentation confirming minimum duration of 4-week trial and failure, intolerance, or contraindication to ONE of the following topical therapies
    a. Corticosteroids (e.g., betamethasone, clobetasol)
    b. Vitamin D analogs (e.g., calcitriol, calcipotriene)
    c. Tazarotene
    d. Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
    e. Anthralin
    f. Coal tar
5. Trial and failure, intolerance, or contraindication to TWO of the following:
    a. Cimzia
    b. Enbrel
    c. Humira, Hadlima, Adalimumab-adaz, Adalimumab-fkjp
    d. Skyrizi
    e. Stelara
    f. Tremfya

6. Trial and failure, intolerance, or contraindication to Cosentyx

Continuation of Therapy

Authorization may be granted for members who have a diagnosis of moderate to severe plaque psoriasis who achieve or maintain positive response as evidenced by low disease activity or improvement in signs and symptoms of the condition when ONE of the following is met

1. Reduction in BSA affected from baseline
2. Improvement in signs and symptoms from baseline (e.g., itching, redness, flaking, scaling, burking, cracking, pain)

Limitations

1. Initial approvals and reauthorizations will be granted for 12 months

References

1. Sotyktu [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; September 2022.
2. Armstrong, AW, Gooderham M, Warren RB, et al. Deucravacitinib versus placebo and apremilast in moderate to severe plaque psoriasis: efficacy and safety results from the 52-week, randomized, double-blinded, placebo-controlled phase 3 POETYK PSO-1 trial. *J AM Acad Dermatol*. 2022;S0190-9622(22)02256-3. doi: 10.1016/j.jaad.2022.07.002. Online ahead of print.
3. Clinicaltrials.gov. National Library of Medicine (US). Identifier: NCT03611751, an investigational study to evaluate experimental medication BMS-986165 compared to placebo and a currently available treatment in participants with moderate-to-severe plaque psoriasis (POETYK-PSO-2). Available from: https://www.clinicaltrials.gov/ct2/show/study/NCT03611751.
4. Menter, A, Gelfand, JM, Connor, C, et al. Joint AAD-NPF guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol.* 2020;82(6): 1445-86.
5. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. J Am Acad Dermatol. 2019;80(4):1029-1072.
6. Coates LC, Soriano ER, Corp N, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA): updated treatment recommendations for psoriatic arthritis 2021. *Nat Rev Rheumatol.* 2022;18(8):465-479.
7. Testing for TB Infection. Centers for Disease Control and Prevention. Retrieved on September 14, 2022 from: https://www.cdc.gov/tb/topic/basics/risk.htm

Review History

01/11/2023 – Created and Reviewed for January P&T. Effective 03/01/2023
11/15/2023 – Reviewed and Updated for Nov P&T; updated BSA requirement to > 3% BSA or crucial body area. Removed TB requirement. Updated preferred agents from having prior use with ALL the preferred products (Cosentyx, Enbrel, Humira, Otezla, Skyrizi and Stelara) to having prior use with 3 of the following agents: Cimzia, Enbrel, Humira or biosimilars, Skyrizi, Stelara, Tremfya, AND Cosentyx. Added requirement of topical therapies. Effective 1/1/2024