Mass General Brigham
Health Plan

Icotyde (icotrokinra)
Effective 01/01/2027

Plan	☐ MassHealth UPPL ☒ Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	N/A		

Overview
Icotyde (icotrikinra) is an interleukin-23 (IL-23) receptor antagonist indicated for the treatment of moderate-to-severe plaque psoriasis in adults and pediatric patients 12 years of age and older who weigh at least 40 kg who are candidates for systemic therapy or phototherapy.

Coverage Guidelines
If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with the requested drug, excluding when the product is obtained as samples or via manufacturer's patient assistance programs
OR
Authorization may be granted when all of the following criteria are met:

1. Diagnosis of moderate to severe plaque psoriasis
2. 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
3. Member meets ONE of the following criteria:
    a. Minimum duration of 4-week trial and failure, contraindication, or intolerance to ONE of the following topical therapies
        i. Corticosteroids (e.g., betamethasone, clobetasol)
        ii. Vitamin D analogs (e.g., calcitriol, calcipotriene)
        iii. Tazarotene
        iv. Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
        v. Anthralin
        vi. Coal tar
    b. Member has severe psoriasis that warrants a biologic DMARD or targeted synthetic therapy as first-line therapy

<u>Continuation of Therapy</u>
Requests for reauthorization will be approved when the following criteria are met:

1. Submission of medical records (e.g. chart notes) documenting an improvement in the member's condition, as evidenced by low disease activity or improvement in signs and symptoms of the condition

Limitations

1. Initial approvals and reauthorizations will be granted for 24 months
2. The following quantity limits apply

Drug Name and Dosage Form	Quantity Limit
Icotyde tablet	1 tablet per day

References

1. Icotyde (icotrokinra) [prescribing information]. Horsham, PA: Janssen Biotech, Inc.; March 2026.

Review History

09/09/2026 – Created and reviewed at September P&T. Effective 01/01/2027.