Mass General Brigham
Health Plan

Sotyktu (deucravacitinib)
Effective 05/01/2025

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
Sotyktu (deucravacitinib) is tyrosine kinase 2 inhibitor approved for the treatment of adult patients with moderate to severe plaque psoriasis 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 the following diagnosis-specific criteria have been met:

Moderate to severe plaque psoriasis
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, intolerance, or contraindication 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 as first-line therapy

<u>Continuation of Therapy</u>
Requests for reauthorization will be approved when all of the following criteria are met:
1. Submission of medical records (e.g., chart notes) demonstrating improvement in 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 limitations apply:

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

References

1. 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.
2. 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.
3. 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.
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. Sotyktu (deucravacitinib) [prescribing information]. Princeton, NJ: Bristol-Myers Squibb Company; September 2022.

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
10/09/2024 – Reviewed and updated at October P&T. Removed age requirement. Updated language for conventional therapies to no longer require submission of medical records or paid claims. Updated criteria to allow for bypassing conventional therapy requirement if member has severe psoriasis that warrants a biologic DMARD as first-line therapy. Added Otezla, Taltz and Wezlana as biologic step options. Updated reauthorization criteria to require documentation of clinical response. Effective 1/1/2025.
06/11/2025 – Reviewed and updated at June P&T. Removed immunomodulator trial and failure requirement. Updated Limitations section to include quantity limits. Effective 09/01/2025.
03/11/2026 – Reviewed and updated for March P&T. Administrative update - changing verbiage in reauthorization criteria from “documentation is submitted” to “submission of medical records (e.g., chart notes…” and updating language for members who are new to the Plan. Effective 05/01/2026.