

UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

Program Number	2026 P 1520-1
Program	Prior Authorization/Notification
Medication	Icotyde™ (icotrokinra)
P&T Approval Date	4/2026
Effective Date	6/1/2026

**1. Background:**

Icotyde (icotrokinra) is an interleukin-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.

**2. Coverage Criteria<sup>a</sup>:**

**A. Plaque Psoriasis**

**1. Initial Authorization**

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

- (1) Diagnosis of moderate to severe plaque psoriasis

**-AND-**

- (2) Patient is not receiving Icotyde in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication

**Authorization will be issued for 12 months.**

**2. Reauthorization**

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

- (1) Documentation of positive clinical response to Icotyde therapy

**-AND-**

- (2) Patient is not receiving Icotyde in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz

(ixekizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication

**Authorization will be issued for 12 months.**

<sup>a</sup> 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, Step Therapy, and/or Medical Necessity may be in place.

**4. Reference:**

1. Icotyde [package insert]. Horsham, PA: Janssen Biotech Inc.; March 2026.

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<b>Change Control</b>	
4/2026	New program