

UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

Program Number	2025 P 1402-4
Program	Prior Authorization/Notification
Medication	Sotyktu™ (deucravacitinib)
P&T Approval Date	1/2023, 7/2023, 7/2024, 7/2025
Effective Date	10/1/2025

**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<sup>a</sup>:**

**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, 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, 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.**

<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 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)
<b>Change Control</b>	
1/2023	New program
7/2023	Updated not receiving in combination language to targeted immunomodulator and updated examples.
7/2024	Annual review. No changes.
7/2025	Annual review. Updated examples with no change to clinical intent.