

<b>Clinical Policy Title:</b>	deucravacitinib
<b>Policy Number:</b>	RxA.785
<b>Drug(s) Applied:</b>	Sotyktu™
<b>Original Policy Date:</b>	01/17/2023
<b>Last Review Date:</b>	12/05/2024
<b>Line of Business Policy Applies to:</b>	All lines of business (except Medicare)

## Criteria

### I. Initial Approval Criteria

#### A. Plaque psoriasis (must meet all):

1. Diagnosis of moderate to severe Plaque Psoriasis (PsO);
2. Trial and failure of  $\geq 3$  months of at least one (1) conventional systemic therapy (methotrexate [MTX], cyclosporin, acitretin) or phototherapy (psoralen plus ultraviolet A light [PUVA]) unless contraindicated or clinically significant adverse effects are experienced;
3. Trial and failure of at least two (2) of the following agents: adalimumab (Abrilada™, Hadlima™, or adalimumab-aaty), Cimzia®, Skyrizi®, Enbrel®, Tremfya®, Stelara®, Otezla, unless contraindicated or clinically significant adverse effects are experienced;
4. Member has BSA involvement  $\geq 3\%$ ;

#### Approval Duration

**All Lines of Business (except Medicare):** 12 months, Split-fill

### II. Continued Therapy Approval

#### A. Plaque psoriasis (must meet all):

1. Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria.

#### Approval Duration

**All Lines of Business (except Medicare):** 12 months

## References

Not Applicable

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	12/08/2022	01/17/2023
Policy was reviewed: 1. Initial Approval Criteria, I.A.5.a: Updated trial and failure criteria from at least 3 to at least 2 agents and also include new drug Amjevita.	04/05/2023	04/13/2023
Policy was reviewed.	10/19/2023	10/19/2023

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Updated trial and failure criteria to include Humira biosimilar.</li> <li>2. Updated Approval duration.</li> <li>3. Removed responding positively criteria.</li> </ol>	<p>11/10/2023</p>	<p>10/19/2023</p>
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. I.A.4: Removed at up to maximally indicated doses and use of a biologic DMARD</li> <li>2. I.A.3: Removed age</li> <li>3. I.A.8: Removed dosing</li> <li>4. Revised continued therapy approval language</li> </ol>		
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Removed prescriber restrictions.</li> <li>2. Updated adalimumab biosimilars.</li> <li>3. Added “Split-fill” to initial criteria approval duration.</li> <li>4. Updated Continued therapy approval to “Member is currently receiving medication that has been authorized..”</li> </ol>	<p>11/25/2024</p>	<p>12/05/2024</p>