STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

DEUCRAVACITINIB

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
DEUCRAVACITINIB	SOTYKTU	48292		GPI-10 (9025052400)	

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Does the patient have a diagnosis of moderate to severe plaque psoriasis (PsO) and meet **ALL** of the following criteria?
   - The patient is 18 years of age or older
   - Therapy is prescribed by or in consultation with a dermatologist
   - The patient has psoriasis covering 3% or more of body surface area (BSA) OR psoriatic lesions affecting the hands, feet, face, or genital area
   - The patient had a trial of or contraindication to ONE conventional therapy (e.g., PUVA [Phototherapy Ultraviolet Light A], UVB [Ultraviolet Light B], topical corticosteroids (e.g., betamethasone dipropionate, clobetasol propionate), calcipotriene, acitretin, methotrexate, cyclosporine)
   - The patient had a trial of or contraindication to TWO of the following preferred agents: Humira (adalimumab), Stelara (ustekinumab), Tremfya (guselkumab), Skyrizi (risankizumab-rzaa), Enbrel (etanercept), Otezla (apremilast), Taltz (ixekizumab), Amjevita (adalimumab-atto), Cyltezo (adalimumab-adbm)

   If yes, **approve for 4 months by HICL or GPI-10 with a quantity limit of #1 per day.**

   If no, do not approve.
   INITIAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **DEUCRAVACITINIB (Sotyktu)** requires the following rule(s) be met for approval:
   A. You have moderate to severe plaque psoriasis (a type of skin condition)
   B. You are 18 years of age or older
   C. Therapy is prescribed by or in consultation with a dermatologist (a type of skin doctor)
   D. You have psoriasis covering 3% or more of body surface area (BSA) OR psoriatic lesions (rashes) affecting the hands, feet, face, or genital area
   E. You had a trial of or contraindication (harmful for) to ONE standard therapy (such as PUVA [Phototherapy Ultraviolet Light A], UVB [Ultraviolet Light B], topical corticosteroids (such as betamethasone dipropionate, clobetasol propionate), calcipotriene, acitretin, methotrexate, cyclosporine)
   (Initial denial continued on next page)

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DEUCRAVACITINIB

INITIAL CRITERIA (CONTINUED)

F. You had a trial of or contraindication (harmful for) to TWO of the following preferred medications: Humira (adalimumab), Stelara (ustekinumab), Tremfya (guselkumab), Skyrizi (risankizumab-rzaa), Enbrel (etanercept), Otezla (apremilast), Taltz (ixekizumab), Amjevita (adalimumab-atto), Cyltezo (adalimumab-adbm)

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

DEUCRAVACITINIB

RENEWAL CRITERIA

1. Does the patient have a diagnosis of moderate to severe plaque psoriasis (PsO) and meet **ALL** of the following criteria?
   - The patient has achieved or maintained clear or minimal disease OR a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more while on therapy
   - The patient had a trial of or contraindication to TWO of the following preferred agents: Humira (adalimumab), Stelara (ustekinumab), Tremfya (guselkumab), Skyrizi (risankizumab-rzaa), Enbrel (etanercept), Otezla (apremilast), Taltz (ixekizumab), Amjevita (adalimumab-atto), Cyltezo (adalimumab-adbm)

   If yes, **approve for 12 months by HICL or GPI-10 with a quantity limit of #1 per day.**
   If no, do not approve.

   RENEWAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **DEUCRAVACITINIB (Sotyktu)** requires the following rule(s) be met for renewal:
   A. You have moderate to severe plaque psoriasis (a type of skin condition)
   B. You have achieved or maintained clear or minimal disease or a decrease in PASI (Psoriasis Area and Severity Index: a tool for evaluating severity of psoriasis) of at least 50% or more while on therapy
   C. You had a trial of or contraindication (harmful for) to TWO of the following preferred medications: Humira (adalimumab), Stelara (ustekinumab), Tremfya (guselkumab), Skyrizi (risankizumab-rzaa), Enbrel (etanercept), Otezla (apremilast), Taltz (ixekizumab), Amjevita (adalimumab-atto), Cyltezo (adalimumab-adbm)

   Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Sotyktu.

REFERENCES

- Sotyktu [Prescribing Information]. Princeton, NJ: Bristol-Myers Squibb Company, September 2022.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 08/28/23
Created: 09/22
Client Approval: 07/23
P&T Approval: 04/23