



Drug Coverage Policy

Effective Date05/01/2026
Coverage Policy Number.....IP0671
Policy Title.....Sotyktu Prior
Authorization Policy

Inflammatory Conditions – Sotyktu Prior Authorization Policy

- Sotyktu™ (deucravacitinib tablets - Bristol Myers Squibb)

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer’s particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer’s benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer’s benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

OVERVIEW

Sotyktu, a tyrosine kinase 2 (TYK2) inhibitor, is indicated for the following uses:¹

- Treatment of moderate to severe **plaque psoriasis** in adults who are candidates for systemic therapy or phototherapy. Limitation of use: Sotyktu is not recommended in combination with potent immunosuppressants.
- Treatment of active **psoriatic arthritis** in adults.

Guidelines

Psoriasis

Joint guidelines from the American Academy of Dermatology (AAD) and National Psoriasis Medical Board have not been updated to include Sotyktu. In 2019, guidelines were published for the management of psoriasis with biologics.² These guidelines list all the biologics approved at the time of publication as agents that may be used as monotherapy for adults with moderate to severe psoriasis. The 2020 AAD and National Psoriasis Medical Board guidelines for management of psoriasis with systemic non-biologic therapies provide recommendations for several medications including methotrexate, cyclosporine, acitretin, as well as apremilast (Otezla®).³

Guidelines from the European Dermatology Forum (2025) include Sotyktu and recommend as second-line therapy for most patients requiring systemic treatment when there is inadequate response, contraindication, or intolerance to conventional systemic agents (e.g., methotrexate, cyclosporine, acitretin).⁴

Psoriatic Arthritis

Guidelines from the American College of Rheumatology have not been updated to include Sotyktu. ACR (2019) recommends TNFis over other biologics and Otezla for use in treatment-naïve patients with psoriatic arthritis and in those who were previously treated with an oral therapy.⁵

Coverage Policy

POLICY STATEMENT

Prior Authorization is required for benefit coverage of Sotyktu. All approvals are for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Sotyktu as well as the monitoring required for adverse events and long-term efficacy, initial approval requires Sotyktu to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Sotyktu is considered medically necessary when ONE of the following is met (1 or 2):

FDA-Approved Indication

- 1. Plaque Psoriasis.** Approve for the duration noted if the patient meets ONE of the following (A or B):
 - A) Initial Therapy.** Approve for 3 months if the patient meets ALL of the following (i, ii, iii, and iv):
 - i.** Patient is ≥ 18 years of age; AND
 - ii.** Patient meets ONE of the following (a or b):
 - a)** Patient has tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant; OR
Note: Examples of one traditional systemic agent include methotrexate, cyclosporine, or acitretin tablets. A 3-month trial of psoralen plus ultraviolet A light

(PUVA) also counts. An exception to the requirement for a trial of one traditional systemic agent for psoriasis can be made if the patient has already had a 3-month trial or previous intolerance to at least one biologic or Otezla (apremilast tablets)/Otezla XR (apremilast extended-release tablets). Refer to [Appendix](#) for examples of biologics used for plaque psoriasis. A patient who has already tried a biologic or Otezla (apremilast tablets)/Otezla XR (apremilast extended-release tablets) for psoriasis is not required to “step back” and try a traditional systemic agent for psoriasis.

b) According to the prescriber, the patient has a contraindication to methotrexate;
AND

iii. Patient will not be taking Sotyktu concurrently with other potent immunosuppressants, including methotrexate; AND

iv. The medication is prescribed by or in consultation with a dermatologist.

B) Patient is Currently Receiving Sotyktu. Approve for 1 year if the patient meets ALL of the following (i, ii, and iii):

i. Patient has been established on therapy for at least 3 months; AND

Note: A patient who has received < 3 months of therapy or who is restarting therapy is reviewed under criterion A (Initial Therapy).

ii. Patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating the requested drug) in at least one of the following: estimated body surface area, erythema, induration/thickness, and/or scale of areas affected by psoriasis; AND

iii. Compared with baseline (prior to initiating the requested drug), patient experienced an improvement in at least one symptom, such as decreased pain, itching, and/or burning; AND

iv. Patient will not be taking Sotyktu concurrently with other potent immunosuppressants, including methotrexate.

2. Psoriatic Arthritis. Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve for 6 months if the patient meets BOTH of the following (i and ii):

i. Patient is \geq 18 years of age; AND

ii. The medication is prescribed by or in consultation with a rheumatologist or dermatologist; OR

B) Patient is Currently Receiving Sotyktu. Approve for 1 year if the patient meets BOTH of the following (i and ii):

i. Patient has been established on the requested drug for at least 6 months; AND

Note: A patient who has received < 6 months of therapy or who is restarting therapy is reviewed under criterion A (Initial Therapy).

ii. Patient meets at least ONE of the following (a or b):

a) When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating Sotyktu); OR

Note: Examples of standardized measures of disease activity include Disease Activity Index for Psoriatic Arthritis (DAPSA), Composite Psoriatic Disease Activity Index (CPDAI), Psoriatic Arthritis Disease Activity Score (PsA DAS), Grace Index, Leeds Enthesitis Score (LEI), Spondyloarthritis Consortium of Canada (SPARCC) enthesitis score, Leeds Dactylitis Instrument Score, Minimal Disease Activity (MDA), Psoriatic Arthritis Impact of Disease (PsAID-12), and/or serum markers (e.g., C-reactive protein, erythrocyte sedimentation rate).

b) Compared with baseline (prior to initiating Sotyktu), patient experienced an improvement in at least one symptom, such as less joint pain, morning stiffness, or

fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths.

Conditions Not Covered

Sotyktu for any other use is considered not medically necessary, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

- 1. Concurrent Use with a Biologic or with a Targeted Synthetic Oral Small Molecule Drug.** This medication should not be administered in combination with another biologic or with a targeted synthetic oral small molecule drug used for an inflammatory condition (see [Appendix](#) for examples). Combination therapy is generally not recommended due to a potentially higher rate of adverse events and lack of controlled clinical data supporting additive efficacy.

References

1. Sotyktu™ tablets [prescribing information]. Princeton, NJ: Bristol Myers Squibb; March 2026.
2. 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.
3. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology – National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol.* 2020;82(6):1445-1486.
4. Nast A, Spuls PI, Dressler C, et al. EuroGuiDerm guideline for the systemic treatment of psoriasis vulgaris. Updated February 2025. Available at: <https://www.guidelines.edf.one/guidelines/psoriasis-guideline>. Accessed on: March 9, 2026.
5. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the treatment of psoriatic arthritis. *Arthritis Care Res (Hoboken).* 2019;71(1):2-29.

Revision Details

Summary of Changes	Review Date	Effective Date
New policy	09/19/2024	11/01/2024
<p>Plaque Psoriasis: For Initial Therapy, in the Note, a 3-month trial or prior intolerance to Otezla (apremilast tablets) or Otezla XR (apremilast extended-release tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis. For Initial Therapy, the requirement “patient has a contraindication to methotrexate, as determined by the prescriber” was modified to “according to the prescriber, the patient has a contraindication to methotrexate”.</p> <p>Conditions Not Covered: For concurrent use with a biologic or with a targeted synthetic oral small molecule drug, the Note was removed stating “this does NOT exclude the use of conventional synthetic DMARDs (e.g.,</p>	10/16/2025	11/01/2025

methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine) in combination with this medication.”		
<p>Psoriatic Arthritis: This new condition for approval was added to the policy.</p> <p>Conditions Not Covered: Concurrent use with other potent immunosuppressants, including methotrexate, was removed and relocated to apply to Plaque Psoriasis indication only.</p> <p>Plaque Psoriasis: For initial therapy and for patients currently receiving Sotyktu, the requirement that the patient will not be taking Sotyktu concurrently with other potent immunosuppressants, including methotrexate, was relocated from Conditions Not Covered section.</p> <p>Appendix: Sotyktu was updated to include psoriatic arthritis indication.</p>	04/02/2026	05/01/2026

The policy effective date is in force until updated or retired.

APPENDIX

	Mechanism of Action	Examples of Indications*
Biologics		
Adalimumab SC Products (Humira®, biosimilars)	Inhibition of TNF	AS, CD, JIA, PsO, PsA, RA, UC
Cimzia® (certolizumab pegol SC injection)	Inhibition of TNF	AS, CD, JIA, nr-axSpA, PsO, PsA, RA
Etanercept SC Products (Enbrel®, biosimilars)	Inhibition of TNF	AS, JIA, PsO, PsA, RA
Infliximab IV Products (Remicade®, biosimilars)	Inhibition of TNF	AS, CD, PsO, PsA, RA, UC
Zymfentra® (infliximab-dyyb SC injection)	Inhibition of TNF	CD, UC
Simponi®, Simponi Aria® (golimumab SC injection, golimumab IV infusion)	Inhibition of TNF	SC formulation: AS, PsA, RA, UC
		IV formulation: AS, PJIA, PsA, RA
Tocilizumab Products (Actemra® IV, biosimilars; Actemra SC, biosimilars)	Inhibition of IL-6	SC formulation: PJIA, RA, SJIA
		IV formulation: PJIA, RA, SJIA
Kevzara® (sarilumab SC injection)	Inhibition of IL-6	RA
Orencia® (abatacept IV infusion, abatacept SC injection)	T-cell costimulation modulator	SC formulation: JIA, PSA, RA
		IV formulation: JIA, PsA, RA
Rituximab IV Products (Rituxan®, biosimilars)	CD20-directed cytolytic antibody	RA
Kineret® (anakinra SC injection)	Inhibition of IL-1	JIA [^] , RA
Omvoh® (mirikizumab IV infusion, SC injection)	Inhibition of IL-23	CD, UC
Ustekinumab Products (Stelara® IV, biosimilars; Stelara SC, biosimilars)	Inhibition of IL-12/23	SC formulation: CD, PsO, PsA, UC
		IV formulation: CD, UC
Siliq® (brodalumab SC injection)	Inhibition of IL-17	PsO
Cosentyx® (secukinumab SC injection; secukinumab IV infusion)	Inhibition of IL-17A	SC formulation: AS, ERA, nr-axSpA, PsO, PsA

		IV formulation: AS, nr-axSpA, PsA
Taltz ® (ixekizumab SC injection)	Inhibition of IL-17A	AS, nr-axSpA, PsA, PsO
Bimzelx ® (bimekizumab-bkzx SC injection)	Inhibition of IL-17A/17F	AS, nr-axSpA, PsA, PsO
Ilumya ® (tildrakizumab-asmn SC injection)	Inhibition of IL-23	PsO
Skyrizi ® (risankizumab-rzaa SC injection, risankizumab-rzaa IV infusion)	Inhibition of IL-23	SC formulation: CD, PSA, PsO, UC
		IV formulation: CD, UC
Tremfya ® (guselkumab SC injection, guselkumab IV infusion)	Inhibition of IL-23	SC formulation: CD, PSA, PsO, UC
		IV formulation: CD, UC
Entyvio ® (vedolizumab IV infusion, vedolizumab SC injection)	Integrin receptor antagonist	CD, UC
Oral Therapies/Targeted Synthetic Oral Small Molecule Drugs		
Otezla ® (apremilast tablets)	Inhibition of PDE4	PsO, PsA
Otezla XR ™ (apremilast extended-release tablets)	Inhibition of PDE4	PsO, PsA
Cibinqo ™ (abrocitinib tablets)	Inhibition of JAK pathways	AD
Olumiant ® (baricitinib tablets)	Inhibition of JAK pathways	RA, AA
Litfulo ® (ritlectinib capsules)	Inhibition of JAK pathways	AA
Leqselvi ® (deuruxolitinib tablets)	Inhibition of JAK pathways	AA
Rinvoq ® (upadacitinib extended-release tablets)	Inhibition of JAK pathways	AD, AS, nr-axSpA, RA, PsA, UC
Rinvoq ® LQ (upadacitinib oral solution)	Inhibition of JAK pathways	PsA, PJIA
Sotyktu ® (deucravacitinib tablets)	Inhibition of TYK2	PsO, PsA
Xeljanz ® (tofacitinib tablets/oral solution)	Inhibition of JAK pathways	RA, PJIA, PsA, UC
Xeljanz ® XR (tofacitinib extended-release tablets)	Inhibition of JAK pathways	RA, PsA, UC
Zeposia ® (ozanimod tablets)	Sphingosine 1 phosphate receptor modulator	UC
Velsipity ® (etrasimod tablets)	Sphingosine 1 phosphate receptor modulator	UC

* Not an all-inclusive list of indications. Refer to the prescribing information for the respective agent for FDA-approved indications; SC – Subcutaneous; TNF – Tumor necrosis factor; AS – Ankylosing spondylitis; CD – Crohn’s disease; JIA – Juvenile idiopathic arthritis; PsO – Plaque psoriasis; PsA – Psoriatic arthritis; RA – Rheumatoid arthritis; UC – Ulcerative colitis; nr-axSpA – Non-radiographic axial spondyloarthritis; IV – Intravenous, PJIA – Polyarticular juvenile idiopathic arthritis; IL – Interleukin; SJIA – Systemic juvenile idiopathic arthritis; ^ Off-label use of Kineret in JIA supported in guidelines; ERA – Enthesitis-related arthritis; DMARD – Disease-modifying antirheumatic drug; PDE4 – Phosphodiesterase 4; JAK – Janus kinase; AD – Atopic dermatitis; AA – Alopecia areata; TYK2 – Tyrosine kinase 2.

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