BlueCross BlueShield
Federal Employee Program

SOTYKTU
(deucravacitinib)

Pre - PA Allowance

None

Prior-Approval Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:

Moderate-to-severe plaque psoriasis (PsO)

AND ALL of the following:

1. Inadequate treatment response, intolerance, or contraindication to either conventional systemic therapy (see Appendix 1) or phototherapy
   a. If the patient is intolerant or contraindicated to one therapy then the patient must have an inadequate response, intolerance, or contraindication to the other treatment option
2. Result for latent TB infection is negative **OR** result was positive for latent TB and patient completed treatment (or is receiving treatment) for latent TB
3. Patient **MUST** have tried the preferred product(s) (see Appendix 2) if adjudicated through the pharmacy benefit unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

AND NONE of the following:

1. Active bacterial, invasive fungal, viral, and other opportunistic infections
2. Severe hepatic impairment (Child Pugh C)
3. Used in combination with potent immunosuppressants azathioprine or cyclosporine
4. Used in combination with any other biologic DMARD or targeted synthetic DMARD (see Appendix 1)
5. Given concurrently with live vaccines

Prior - Approval Limits

Quantity 90 tablets per 90 days

Duration 12 months

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Prior – Approval *Renewal* Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:

Plaque psoriasis (PsO)

AND ALL of the following:

1. Condition has improved or stabilized
2. Patient **MUST** have tried the preferred product(s) (see Appendix 2) if adjudicated through the pharmacy benefit unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

AND NONE of the following:

1. Active bacterial, invasive fungal, viral, and other opportunistic infections
2. Used in combination with potent immunosuppressants azathioprine or cyclosporine
3. Used in combination with any other biologic DMARD or targeted synthetic DMARD (see Appendix 1)
4. Given concurrently with live vaccines

Prior - Approval *Renewal* Limits

Quantity 90 tablets per 90 days

Duration 18 months

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Appendix 1 - List of DMARDs

Conventional disease-modifying antirheumatic drugs (DMARDs)

Generic Name	Brand Name
azathioprine	Azasan, Imuran
cyclophosphamide	Cytoxan
cyclosporine	Neoral, Gengraf, Sandimmune
hydroxychloroquine	Plaquenil
leflunomide	Arava
methotrexate	Rheumatrex, Trexall
mycophenolate	Cellcept
sulfasalazine	Azulfidine, Sulfazine

Biological disease-modifying antirheumatic drugs (DMARDs)

Generic Name	Brand Name
abatacept	Orencia
adalimumab	Humira
anakinra	Kineret
bimekizumab-bkzx	Bimzelx
brodalumab	Siliq
certolizumab	Cimzia
etanercept	Enbrel
golimumab	Simponi/Simponi Aria
guselkumab	Tremfya
infliximab	Remicade
ixekizumab	Taltz
risankizumab-rzaa	Skyrizi
rituximab	Rituxan
sarilumab	Kevzara
secukinumab	Cosentyx
spesolimab-sbzo	Spevigo
tildrakizumab-asmn	Ilumya
tocilizumab	Actemra
ustekinumab	Stelara
vedolizumab	Entyvio

Targeted synthetic disease-modifying antirheumatic drugs (DMARDs)

Generic Name	Brand Name
apremilast	Otezla
baricitinib	Olumiant
deucravacitinib	Sotyktu

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tofacitinib	Xeljanz/XR
upadactinib	Rinvoq

Appendix 2 - List of Preferred Products

Diagnosis	Standard Option/Basic Option Preferred Products	Blue Focus Preferred Products
Plaque Psoriasis (PsO)	*must try **TWO** preferred products: Enbrel Humira** Otezla Skyrizi Stelara (SC) Taltz Tremfya	*must try **ONE** preferred product: Enbrel Humira**

**Including all preferred biosimilars (see reference product criteria)