AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Icotyde	Page:	1 of 3
Effective Date:	8/11/2026	Last Review Date:	7/14/2026
Applies to:	☒New Jersey		

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Icotyde under the patient's prescription drug benefit.

Description:

FDA-approved Indications
Treatment of moderate to severe plaque psoriasis (PsO) in adults and pediatric patients 12 years of age and older who weigh at least 40 kilograms (kg) who are candidates for systemic therapy or phototherapy.

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Icotyde

Policy/Guideline:

Documentation

Submission of the following information is necessary to initiate the prior authorization review:
Initial requests
- Chart notes or medical record documentation of affected area(s) and body surface area (BSA) affected (if applicable).
- Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.

Continuation requests
Chart notes or medical record documentation of decreased body surface area (BSA) affected and/or improvement in signs and symptoms.

Prescriber Specialties

This medication must be prescribed by or in consultation with a dermatologist.

Coverage Criteria

The patient is unable to take a preferred ustekinumab product and ONE additional preferred product (a preferred adalimumab product, Enbrel, Cosentyx, tofacitinib, Otezla) for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

Plaque psoriasis (PsO)
Authorization of 12 months may be granted for members 12 years of age and older who have previously received a biologic or targeted synthetic drug indicated for treatment of moderate to severe plaque psoriasis.

Authorization of 12 months may be granted for members 12 years of age and older for treatment of moderate to severe plaque psoriasis when ANY of the following criteria is met:

- High impact sites (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
- At least 10% of body surface area (BSA) is affected.
- At least 3% of body surface area (BSA) is affected and the member meets EITHER of the following criteria:
  - Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin.
  - Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin (see Appendix).

Continuation of Therapy

Authorization of 12 months may be granted for all members 12 years of age and older (including new members) who are using the requested medication for moderate to severe plaque psoriasis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when EITHER of the following is met:

- Reduction in body surface area (BSA) affected from baseline
- Improvement in signs and symptoms from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)

Other

Member cannot use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

Appendix

Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine, or Acitretin

- Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
- Drug interaction
- Risk of treatment-related toxicity
- Pregnancy or currently planning pregnancy
- Breastfeeding

- Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
- Hypersensitivity
- History of intolerance or adverse event

Approval Duration and Quantity Restrictions:

Initial and Renewal Approval: 12 months

Quantity Level Limit: Reference Formulary for drug specific quantity level limits

References:

1. Icotyde [package insert]. Horsham, PA: Janssen Biotech, Inc.; March 2026.
2. Menter A, Gelfand JM, Connor C, et al. Joint AAD-NPF guidelines of care for the management of psoriasis with systemic nonbiologic therapies. J Am Acad Dermatol. 2020;82(6): 1445-86.
3. 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.
4. Menter A, Cordero KM, Davis DM, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis in pediatric patients. J Am Acad Dermatol. 2020;82(1):161-201.
5. Smith CH, You ZZN, Bale T, et al. British Association of Dermatologists guidelines for biologic therapy for psoriasis 2020: a rapid update. Br J Dermatol. 2020:183(4):628-637.