Icotrokinra, a Targeted Oral Peptide, in Participants With Moderate-to-Severe Plaque Psoriasis and Psoriatic Arthritis: Results From a Pooled Analysis of the Phase 3 ICONIC-LEAD, ICONIC-ADVANCE 1, and ICONIC-ADVANCE 2 Trials

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Key Takeaways

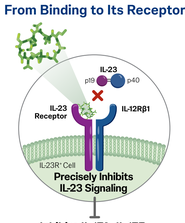
- **In a large pooled cohort of adults and adolescents with moderate-to-severe plaque PsO and a self-reported medical history of PsA, pts who were treated with ICO demonstrated:**
  - ✓ **Early and substantial improvements in PsA disease activity and pain through W16, with nearly one-half reporting ≥50% improvement in these PsA-specific outcomes**
  - ✓ **High rates of nail and scalp PsO clearance vs PBO at W16, as well as an ICO AE profile similar to PBO, consistent with the overall PsO study populations evaluated in current and prior ICO trials[3,6,7,10]**
- **Acknowledging the inherent limitations of post hoc subgroup analyses, findings support the potential of ICO as a targeted oral treatment option for active PsA**

Background

Icotrokinra (ICO), the first and only targeted oral peptide:

- Approved for the treatment of moderate-to-severe plaque psoriasis (PsO) in adults and pediatric patients (≥12 years, ≥40 kg) who are candidates for systemic therapy or phototherapy[1]
- Precisely blocks the interleukin (IL)-23 receptor and inhibits IL-23 pathway signaling[2]
- Currently under investigation for the treatment of psoriatic arthritis (PsA) in the parallel ICONIC-PsA 1 & 2 studies[3-5]

Icotrokinra Blocks IL-23 From Binding to Its Receptor



IL-12Rβ1=interleukin-12 receptor beta 1.

Objective

Evaluate PsA- and PsO-relevant outcomes and adverse events (AEs) through Week (W) 16 in a pooled cohort of participants (pts) with moderate-to-severe PsO and a self-reported medical history of PsA (PsO+PsA)

Pooled ICONIC-LEAD, -ADVANCE 1, & -ADVANCE 2: ICO vs PBO Through W16

Key Inclusion Criteria

- ≥12 years (ICONIC-LEAD)
- ≥18 years (ICONIC-ADVANCE 1 & 2)
- Plaque PsO for ≥26 weeks
- BSA ≥10%, PASI score ≥12, and IGA score ≥3
- Candidate for phototherapy or systemic therapy for plaque PsO

Assessments in Pts With PsO+PsA

PsA-Specific PROs at W8 & W16:

- PtGA of PsA disease activity (VAS)
- Patient's Assessment of PsA Pain (VAS)

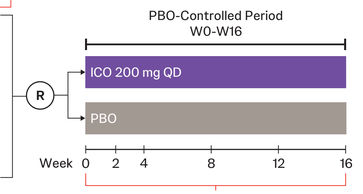
High-Impact Site PsO at W16:

- Nail PsO (mNAPSI and f-PGA)
- Scalp PsO (ss-IGA)

AEs Through W16

Pts randomized to ICO or PBO from W0-W16 pooled across phase 3 studies:

- **ICONIC-LEAD**[6] (N=684[a]) 2:1
- **ICONIC-ADVANCE 1**[7] (N=467) 2:1
- **ICONIC-ADVANCE 2**[7] (N=404[b]) 4:1



[a]Includes 66 adolescents. [b]ICONIC-ADVANCE 2 enrolled 404 pts in the ICO and PBO groups, of whom 401 were evaluable for efficacy. [c]Includes pooled ICO- and PBO-randomized pts from the phase 3 ICONIC-LEAD, ICONIC-ADVANCE 1, and ICONIC-ADVANCE 2 studies. [d]Among pts in the pooled FAS and with a self-reported medical history of PsA, 213 were evaluable for efficacy. ***BSA****=body surface area,* ***FAS****=full analysis set,* ***f-PGA****=Fingernail Physician's Global Assessment,* ***IGA****=Investigator's Global Assessment,* ***mNAPSI****=modified Nail Psoriasis Severity Index,* ***PASI****=Psoriasis Area and Severity Index,* ***PBO****=placebo,* ***PRO****=participant-reported outcome,* ***PtGA****=Patient's Global Assessment,* ***QD****=once daily,* ***R****=randomization,* ***ss-IGA****=scalp-specific Investigator's Global Assessment,* ***VAS****=visual analog scale.*

Outcomes & Analyses

PsA-Specific PROs at W8 & W16:

- Least squares mean (LSM) change from baseline in PtGA of PsA disease activity and in PsA Patient Pain[a,c]
- ≥50% improvement from baseline in PtGA of PsA disease activity and in PsA Patient Pain[b,d,e]

High-Impact Site PsO at W16:

- LSM percent change from baseline in mNAPSI (among pts with a baseline mNAPSI score >0)[a,c]
- f-PGA 0/1 and 0 (among pts with a baseline f-PGA score ≥2)[b,d]
- ss-IGA 0/1 and 0 (among pts with a baseline ss-IGA score ≥2)[b,d]

AEs Through W16:

- Safety assessments for pooled ICO and PBO groups

ss-IGA 0/1 reflects score 0/1 and ≥2-grade improvement from baseline. [a]No improvement from baseline / [b]Non-responder imputation assigned after pts discontinued study drug due to a lack of efficacy or an AE of worsening PsO, or initiated prohibited medication that could impact PsO. Observed data were used for pts who discontinued study drug for other reasons. [c]The remaining missing data were not imputed and were accounted for through the MMRM model. [d]After accounting for the intercurrent events, pts with missing data were considered nonresponders. [e]The ≥50% improvement from baseline in PtGA of PsA disease activity and Patient Pain represent components of American College of Rheumatology 50% (ACR50) response criteria, a stringent, clinically relevant measure of improvement in PsA.[8,9] ***MMRM****=mixed-effect model for repeated measures.*

Results

Baseline characteristics of pts with PsO+PsA reflected substantial skin PsO and moderate PsA disease activity/pain

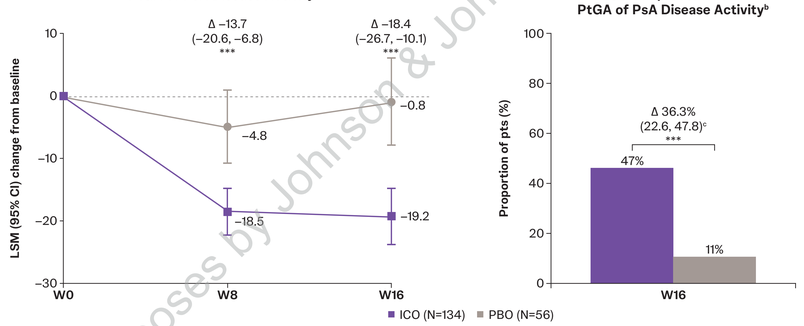
- Characteristics of pts with PsO+PsA were generally consistent with those of the overall study populations

Baseline Characteristics	ICO (N=149)	PBO (N=67)
Demographics		
Age, yrs	49.6 (12.8)	49.1 (13.0)
Female	36%	45%
Race, Asian / Black / White	17% / 3% / 77%	13% / 3% / 84%
BMI, kg/m²	31.3 (7.5)	30.4 (7.6)
PsA Characteristics		
PtGA of PsA disease activity[a] (0-100)	48.0 (27.0)	50.1 (27.1)
PsA Patient Pain[a] (0-100)	49.3 (27.6)	53.4 (28.7)
PsO Characteristics		
PsO disease duration, yrs	19.1 (12.0)	20.4 (13.8)
% of BSA with PsO	24.8 (14.3)	26.0 (15.0)
IGA score Moderate (3) / Severe (4)	83% / 17%	70% / 30%
PASI (0-72)	19.4 (6.5)	20.6 (8.2)
High-Impact Site PsO Characteristics		
mNAPSI score[b] (0-130)	21.0 (18.6)	21.5 (19.5)
f-PGA score[c] Mild (2) /Moderate (3) / Severe (4)	24% / 18% / 3%	13% / 18% / 1%
ss-IGA score[c] Mild (2) / Moderate (3) / Severe (4)	10% / 61% / 16%	13% / 42% / 30%

Data shown are mean (SD), unless otherwise noted. [a]ICO N=136/PBO N=57. [b]Among pts with a baseline f-PGA score >0: ICO N=84/PBO N=33. [c]ICO N=148/PBO N=67. ***BMI****=body mass index,* ***SD****=standard deviation.*

PtGA: ICO-treated pts reported greater mean improvement in PsA disease activity vs PBO; nearly one-half reported ≥50% improvement at W16

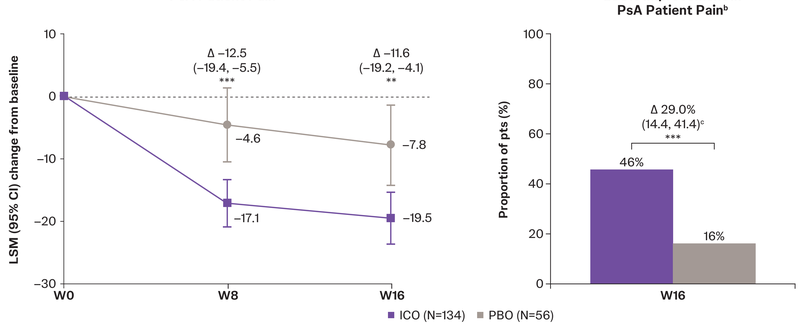
- Separation between ICO and PBO in PsA disease activity was evident by W8 (at the first follow-up for PsA disease activity)



Nominal ***p<0.001 vs PBO.*** *Among pts in the pooled FAS and with a self-reported medical history of PsA, 213 were evaluable for efficacy. [a]LSM, LSM differences, and p-values were based on the MMRM model with treatment group, visit, study, baseline PtGA of PsA disease activity, baseline PtGA of PsA disease activity by visit interaction, and treatment group by visit interaction as covariates. [b]Among pts with baseline PtGA of PsA disease activity. [c]Treatment difference and 95% CI (using Miettinen-Nurminen method) were calculated adjusting for study, baseline weight category for adults, and geographic region using Mantel-Haenszel weights; p-value was based on Cochran-Mantel-Haenszel chi-square test stratified by study, baseline weight category for adults, and geographic region.* ***CI****=confidence interval.*

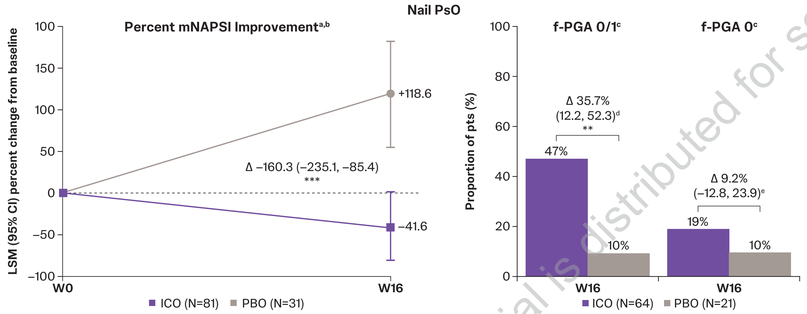
Patient Pain: ICO-treated pts reported greater mean improvement in PsA pain vs PBO, with nearly one-half reporting ≥50% improvement at W16

- Separation between ICO and PBO in PsA Patient Pain was evident by W8 (at the first follow-up for PsA Patient Pain)



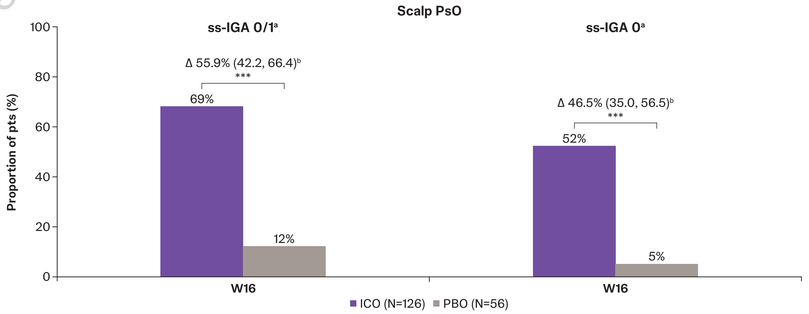
Nominal ***p<0.01, ***p<0.001 vs PBO.*** *Among pts in the pooled FAS and with a self-reported medical history of PsA, 213 were evaluable for efficacy. [a]LSM, LSM differences, and p-values were based on the MMRM model with treatment group, visit, study, baseline PsA Patient Pain, baseline PsA Patient Pain by visit interaction, and treatment group by visit interaction as covariates. [b]Among pts with baseline PsA Patient Pain. [c]Treatment difference and 95% CI (using Miettinen-Nurminen method) were calculated adjusting for study, baseline weight category for adults, and geographic region using Mantel-Haenszel weights; p-value was based on Cochran-Mantel-Haenszel chi-square test stratified by study, baseline weight category for adults, and geographic region.*

Nail PsO: ICO-treated pts had a 42% mean percent mNAPSI improvement; nearly 50% achieved clear/almost clear nail PsO, at W16



Nominal ***p<0.01, ***p<0.001 vs PBO.*** *Among pts in the pooled FAS and with a self-reported medical history of PsA, 213 were evaluable for efficacy. [a]Among pts with a baseline mNAPSI score >0. [b]LSM, LSM difference, and p-value were based on the MMRM model with treatment group, visit, study, baseline mNAPSI score, baseline mNAPSI score by visit interaction, and treatment group by visit interaction as covariates. [c]Among pts with a baseline f-PGA score ≥2. [d]Treatment differences and 95% CIs (using Miettinen-Nurminen method) were calculated adjusting for study using Mantel-Haenszel weights; p-value was based on Cochran-Mantel-Haenszel chi-square test stratified by study. [e]Treatment difference and 95% CI were based on exact method.*

Scalp PsO: ~70% of ICO-treated pts achieved clear/almost clear scalp PsO, and >50% achieved completely clear scalp PsO, at W16



Nominal ***p<0.001 vs PBO.*** *Among pts in the pooled FAS and with a self-reported medical history of PsA, 213 were evaluable for efficacy. [a]Among pts with a baseline ss-IGA score ≥2. [b]Treatment differences and 95% CIs (using Miettinen-Nurminen method) were calculated adjusting for study using Mantel-Haenszel weights; p-values were based on Cochran-Mantel-Haenszel chi-square test stratified by study.* ***ss-IGA 0/1****=ss-IGA score 0/1 and ≥2-grade improvement from baseline.*

ICO AE profile: Similar to PBO through W16 in pts with PsO+PsA

Pooled Safety in Pts With PsO+PsA Through W16[a]	ICO (N=148)	PBO (N=67)
Mean weeks of follow-up	15.8	15.3
Any AE	73 (49%)	34 (51%)
Most common AE (≥5%)		
Headache	10 (7%)	2 (3%)
AE leading to discontinuation	3 (2%)	5 (7%)
Infection	28 (19%)	17 (25%)
Most common infection (≥5%)		
Upper respiratory tract infection	7 (5%)	2 (3%)
Gastrointestinal AE	12 (8%)	4 (6%)
Malignancy	2 (1%)	1 (1%)

Data shown are n (%), unless otherwise noted. Safety analysis set includes all randomized and treated pts. [a]Among pts in the pooled FAS and with a self-reported medical history of PsA.

PRESENTED AT: European Alliance of Associations for Rheumatology (EULAR); June 3-6, 2026; London, England. **REFERENCES: 1.** Janssen Biotech, Inc. ICOTYDE™ (icotrokinra) tablets, for oral use. Revised 3/2026 (prescribing information). https://www.jnjlabels.com/package-insert/product-monograph/prescribing-information/ICOTYDE-pi.pdf. **2.** Fourie AM. *Sci Rep.* 2024;14:17515. **3.** Merola JF. Poster presented at: European Alliance of Associations for Rheumatology (EULAR); June 11-14, 2025; Barcelona, Spain. **4.** https://clinicaltrials.gov/study/NCT06878404. **5.** https://clinicaltrials.gov/study/NCT06807424. **6.** Bissonnette R. *N Engl J Med.* 2025;393:1784-95. **7.** Stein Gold L. *Lancet.* 2025;406:1363-74. **8.** Felson DT. *Arthritis Rheum.* 1995;38:727-35. **9.** Chung CP. *Ann Rheum Dis.* 2006;65:1602-7. **10.** Gooderham M. *NEJM Evid.* 2025;4:EVIDoa2500155. **ACKNOWLEDGMENTS:** Medical writing support was provided by Kiley Margolis, PharmD, of Lumanity Communications Inc., under the direction of the authors in accordance with Good Publication Practice guidelines (DeTora LM. *Ann Intern Med.* 2022;175:1298-1304) and funded by Johnson & Johnson. This presentation was sponsored by Johnson & Johnson. **DISCLOSURES: IBM:** Served as a consultant for AbbVie, Amgen, AstraZeneca, Bristol Myers Squibb, Cabaletta Bio, Compugen, Dextera Biosciences, Eli Lilly, Gilead, GSK, Johnson & Johnson, MoonLake, Novartis, Pfizer, Roche, Sanofi, and UCB; received grant/research support from Amgen, AstraZeneca, Bristol Myers Squibb, Eli Lilly, GSK, Johnson & Johnson, Novartis, Roche, and UCB; is a share-option holder of Cabaletta Bio, Causeway Therapeutics, Compugen, Dextera Biosciences, and Montai Therapeutics; and is a trustee of Arthritis UK. **LSG:** Served as an investigator, advisor, and/or speaker for AbbVie, Amgen, Bristol Myers Squibb, Eli Lilly, Galderma, Johnson & Johnson, LEO Pharma, Pfizer, Regeneron, Sanofi, and Takeda. **RB:** Served as an advisory board member, consultant, speaker, and/or investigator for and received honoraria and/or grants from AbbVie, Alumis, Amgen, AnaptysBio, Arcutis, BMS/Celgene, Dermavant, Eli Lilly, Johnson & Johnson, LEO Pharma, Nimbus, Oruka, Takeda, UCB, Ventyx Biosciences, Vyne, Xencor, Zai Lab, and Zura Bio; and is an employee and shareholder of Innovaderm Research. **MGL:** Employee of Mount Sinai and receives research funds from AbbVie, Arcutis, Avotres Therapeutics, Boehringer Ingelheim, Bristol Myers Squibb, Cara Therapeutics, Clexio, Dermavant Sciences, Eli Lilly, Incyte, Inozyme, Johnson & Johnson, Oruka, Pfizer, Sanofi-Regeneron, and UCB, and is a consultant for AbbVie, Added Health, Alkium, Almirall, AltruBio Inc., Alumis, Amgen, Apogee, Arcutis, AstraZeneca, Atomwise, Avotres Therapeutics, Boehringer Ingelheim, Bristol Myers Squibb, Castle Biosciences, Celltrion, CorEvitas, Dermavant Sciences, Dermsquared, Edesa Biotech, Eli Lilly, Evommune, Facilitation of International Dermatology Education, Forte Biosciences, Galderma, Genentech, Incyte, Johnson & Johnson, LEO Pharma, Mayne Pharmaceuticals, Meiji Seika Pharma, Mindera, Mirium Pharmaceuticals, Moonlake, Novartis, Oruka, Pfizer, Sanofi-Regeneron, Revolo, Seanergy, Strata, Sun Pharma, Takeda, Trevi, and Verrica. **OR-S, JC, Y-WY, SDC, CI, SL, TS,** and **KL:** Employees of Johnson & Johnson; may own stock/stock options in Johnson & Johnson. **AWA:** Served as a speaker, consultant, and/or investigator for AbbVie, Amgen, Arcutis, Bristol Myers Squibb, Dermavant, Eli Lilly and Company, Galderma, Incyte, Johnson & Johnson, LEO Pharma, Novartis, Pfizer, Regeneron, Sanofi, Takeda, and UCB. **JFM:** Served as a consultant and/or investigator for AbbVie, Amgen, AstraZeneca, Biogen, Boehringer Ingelheim, Bristol Myers Squibb, Dermavant, Eli Lilly, Galderma, Johnson & Johnson, Moonlake, Novartis, Oruka, Pfizer, Regeneron, Sanofi, Sun Pharma, and UCB.