Prior Treatment Patterns, Clinical Characteristics, and Disease Burden Among Patients Initiating Icotrokinra

Hsien-Yen Chang,[1] Alexander Litvintchouk,[2] Cindy Chen,[1] Santiago Munoz,[2] Timothy Fitzgerald,[2] Christine Cornejo,[2] Steve Feldman[3]

[1]Johnson & Johnson, Titusville, NJ, USA; [2]Johnson & Johnson, Horsham, PA, USA; [3]Wake Forest University, Winston-Salem, NC, USA

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Background

- Icotrokinra (ICO), a first-in-class targeted oral peptide, precisely blocks the interleukin (IL)-23 receptor and is approved for the treatment of moderate-to-severe plaque psoriasis (PsO) in adults and adolescents ≥12 years of age who are candidates for systemic therapy[1]

Objective

To characterize the demographics, clinical characteristics, prior treatment patterns, and disease burden of early initiators of ICO in routine clinical practice

Methods

Study Design and Data Source

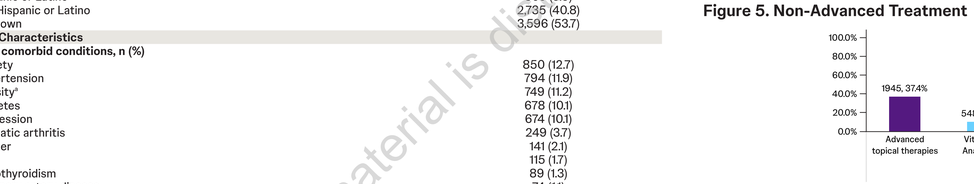
- A retrospective cohort study using Modernizing Medicine (ModMed) Dermatology Real World Data (RWD)
- ModMed is a de-identified dataset derived from the Electronic Medical Assistant (EMA®), a dermatology-specific electronic health record (EHR) database, and comprises data from private-practice dermatologists
- ModMed RWD are geographically and age representative of the United States population

Study Population

- Patients aged ≥12 years with PsO who initiated ICO on or after FDA approval[1] (March 17, 2026 through July 3, 2026) (**Figure 1**). Index date was defined as the first ICO record
- A patient was included in the ModMed database if they had at least one PsO diagnosis*
- Eligible patients for this study had ≥1 PsO diagnosis before index, no prior ICO use, and ≥1 activity record during the 12-month baseline period (**Figure 2**)

Excluded patients with the following diagnoses: Generalized Pustular Psoriasis, Pustular Psoriasis, Psoriatic Arthropathy, Psoriatic Arthritis, Dactylitis (Psoriatic), Guttate Psoriasis, Guttatte Psoriasis (known spelling variant in the source EHR), Palmoplantar Pustulosis, Palmoplantar Psoriasis, Palmoplantar Dermatitis, Acrodermatitis Continua of Hallopeau, Dermatitis Repens

Figure 1. Study Design



ICO=icotrokinra, PsO=psoriasis.

Data Analysis and Outcome Measures

- Patient baseline demographics, comorbidities, treatment history, and clinical outcomes were summarized descriptively (**Table 1**)
  - Percentages (%) were calculated among those with available data
- Prior treatments were categorized using drug name, Generic Product Identifier (GPI) and Healthcare Common Procedure Coding System (HCPCS) codes as:
  - Advanced treatments (ADTs; biologic disease-modifying antirheumatic drugs [bDMARDs], oral small-molecule drugs [SMDs]) or conventional treatments (non-ADTs; topical treatments, conventional synthetic disease-modifying antirheumatic drugs [csDMARDs], phototherapy, opioids, systemic therapies)
- Baseline treatment outcomes and disease status were assessed from the most recent record within 3 months prior to or on the index date. Assessments included:
  - Physician Global Assessment[2] (PGA)
  - Body Surface Area[3] (BSA)
  - Itch Numeric Rating Scale[4] (NRS)
  - Body site of disease involvement was captured from both patient-reported assessments and diagnosis-associated clinical documentation and categorized into clinically meaningful anatomical regions, including feet, head, scalp, face, arms, legs, genitals, chest/abdomen (midsection), and hands
  - Diagnosis status was provided by clinicians. Descriptions were standardized into clinically relevant categories, including: improved, well controlled, resolving, resolved, inadequately controlled, worsening, stable, and unchanged

Synopsis

This retrospective cohort study used ModMed Dermatology RWD to characterize early initiators of ICO in routine clinical practice

Among 6,700 initiators, 88.2% were treatment-experienced; among those with available data, 86.0% had moderate-to-severe disease based on PGA, 52.7% had an itch NRS score ≥6, and 81.4% were not at treatment goal

These findings demonstrate that regardless of prior treatment exposure, early ICO initiators experienced substantial disease burden

Key Takeaways

Early ICO initiators had substantial disease burden at baseline, including moderate-to-severe skin involvement, persistent itch, involvement of high-impact sites, and failure to achieve treatment goals-highlighting an ongoing unmet need in PsO

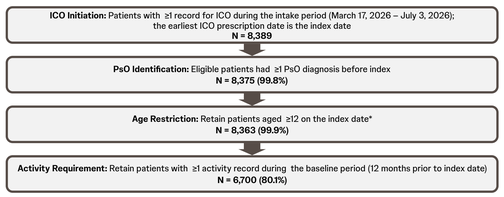
As a targeted oral peptide, ICO provides an innovative treatment option for PsO that may address the needs of patients with inadequate disease control

Results

Patient Characteristics

- A total of 6,700 ICO initiators meeting study eligibility were identified (**Figure 2**)
- The mean (SD) age was 50.8 years (17.6), with 47.1% of patients aged 40 to 64 years; 55.4% of patients were female and 46.0% were White (84.0% among patients with a known race) (**Table 1**)
- The most common baseline comorbidities were anxiety (12.7%), hypertension (11.9%), obesity (11.2%), and diabetes (10.1%)

Figure 2. Patient Attrition



*Date of birth was set as mid-year (July 1) of the date of birth year ModMed provides. **ICO**=icotrokinra, **PsO**=psoriasis.*

Table 1. Patient Demographics and Clinical Characteristics

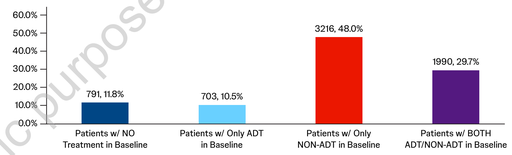
Characteristic	N = 6,700
Demographics	
Age category at index, n (%)	
12–17 years	174 (2.6)
18–39 years	1,706 (25.5)
40–64 years	3,153 (47.1)
≥65 years	1,667 (24.9)
Sex, n (%)	
Male	2,979 (44.5)
Female	3,709 (55.4)
Unknown	12 (0.2)
Race, n (%)	
White	3,085 (46.0)
African American	216 (3.2)
Asian	193 (2.9)
Other	179 (2.7)
Unknown	2,562 (38.2)
Ethnicity, n (%)	
Hispanic or Latino	369 (5.5)
Not Hispanic or Latino	2,735 (40.8)
Unknown	3,596 (53.7)
Clinical Characteristics	
General comorbid conditions, n (%)	
Anxiety	850 (12.7)
Hypertension	794 (11.9)
Obesity[a]	749 (11.2)
Diabetes	678 (10.1)
Depression	674 (10.1)
Psoriatic arthritis	249 (3.7)
Cancer	141 (2.1)
Pain	115 (1.7)
Hypothyroidism	89 (1.3)
Coronary artery disease	74 (1.1)

*Percentages (%) were calculated among those with available information. [a]Patients with a BMI of 30 kg/m² or greater were classified as having obesity. **BMI**=body mass index.*

Treatment Experience at Baseline

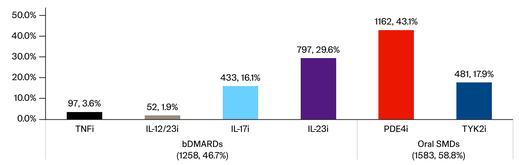
- Most were treatment-experienced during baseline (88.2%); 3,216 (48.0%) had received only non-ADT, 703 (10.5%) had received only ADT, and 1,990 (29.7%) had received both treatment types (**Figure 3**)
- Among 2,693 patients with prior ADT, 46.7% received bDMARDs and 58.8% received oral SMDs; IL-23i and IL-17i were the most used bDMARDs (29.6% and 16.1%, respectively) (**Figure 4**)
- Among 5,206 patients with prior non-ADTs, 98.7% received topical treatments and 8.6% received csDMARDs or phototherapy. Corticosteroids were the most common topical treatment (84.4%) (**Figure 5**)

Figure 3. Treatment by Group



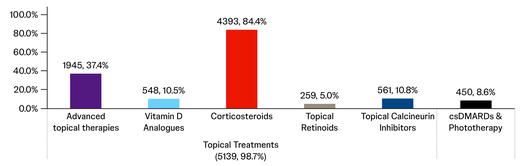
*Percentages (%) were calculated among those with available information. **ADT**=advanced treatments.*

Figure 4. Advanced Treatment by Class



*Percentages (%) were calculated among those with available information. **bDMARD**=biologic disease-modifying antirheumatic drug, **IL-12/23i**=interleukin-12/23 inhibitor, **IL-17i**=interleukin-17 inhibitor, **IL-23i**=interleukin-23 inhibitor, **PDE4i**=phosphodiesterase-4 inhibitor, **SMD**=small-molecule drug, **TNFi**=tumor necrosis factor inhibitor, **TYK2i**=tyrosine kinase 2 inhibitor.*

Figure 5. Non-Advanced Treatment

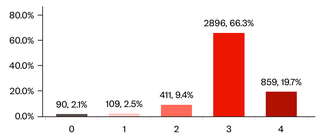


*Percentages (%) were calculated among those with available information. **csDMARD**=conventional synthetic disease-modifying antirheumatic drug.*

Outcome Measures at Baseline Among Patients with Data

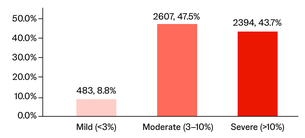
- Among 4,365 patients with available data, disease severity per PGA was moderate (score = 3) in 66.3% and severe (score = 4) in 19.7% of patients (**Figure 6**)
- In the 5,484 patients with available BSA data, 47.5% had moderate BSA (3–10%) and 43.7% had severe BSA involvement (>10%) (**Figure 7**)
- Among 4,961 patients with available self-reported itch NRS data, 22.9% reported moderate itch (score 4–5) and 52.7% reported severe itch (score ≥6) (**Figure 8**)
- Among 2,803 patients with documented high-impact affected body sites, scalp (27.3%), head (22.7%), face (22.1%), hands (11.5%), genitals (7.5%), and feet (6.2%) were commonly involved (**Figure 9**)
- Among the 4,650 patients with clinician-reported baseline disease status, 81.4% had inadequately controlled or were not at treatment goal, and 10.8% had worsening disease (**Figure 10**)

Figure 6. Physician Global Assessment



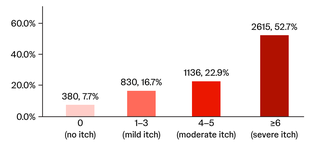
Percentages (%) were calculated among those with available information. Scale: 0=clear, 1=almost clear, 2=mild, 3=moderate, 4=severe disease.

Figure 7. Body Surface Area



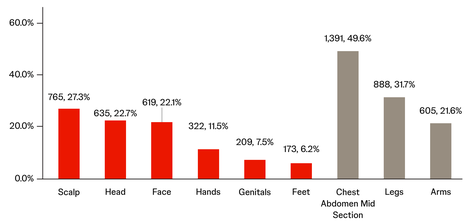
Percentages (%) were calculated among those with available information.

Figure 8. Itch Numeric Rating Scale



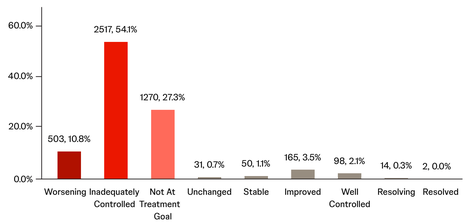
Percentages (%) were calculated among those with available information. Scale: 0=no itch, 10=worst imaginable itch.

Figure 9. Affected Body Sites



Percentages (%) were calculated among those with available information. Note: Scalp includes records explicitly documented as scalp or hair-related terms. Head includes other head-region anatomical terms (ear, temple, tragus, concha, postauricular region, etc). Categories are assigned according to predefined mapping rules and are not intended to imply separate anatomical systems.

Figure 10. Diagnosis Status



Percentages (%) were calculated among those with available information. Note: The pre-index outcomes were assessed from the most recent record within 3 months prior to or on the index date.

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PRESENTED BY: Santiago Munoz at The Society of Dermatology Physician Associates (SDPA) Annual Fall Dermatology Conference, November 11–15, 2026; Hollywood, FL, USA. **REFERENCES: 1.** US Food and Drug Administration, Novel drug approvals for 2026. Accessed September 4, 2026. https://www.fda.gov/drugs/novel-drug-approvals-fda/novel-drug-approvals-2026. **2.** Pascoe VL, et al. *JAMA Dermatology*. 2015;151(4):375–381. **3.** Afifi Y, et al. In: *Agache's Measuring the Skin*. Springer; 2015:1–4. **4.** Kimball AB, et al. *British Journal of Dermatology*. 2016;175(1):157–162. **ACKNOWLEDGMENTS:** Analytical support was provided by Jack Hamilton and Chao Cheng. Medical writing and editorial support, under the direction of the authors, were provided by Cobbs Creek Healthcare, LLC, and funded by Johnson & Johnson. Layout design and formatting for this encore presentation were provided by Mugdha Rokade (SIRO Medical Writing Pvt. Ltd., India). **FUNDING:** This research was funded by Johnson & Johnson. **DISCLOSURES: H-YC, AL, CIC, SM, TF,** and **CNC** are employees of Johnson & Johnson and may own Johnson & Johnson stock or stock options. **SF** has received research, speaking, and/or consulting support from AbbVie, Accordant, Almirall, Alovtech, Amgen, Arcutis, Arena, Argenx, Biocon, Boehringer Ingelheim, Bristol Myers Squibb, Caremark, Celgene, Dermavant, Eli Lilly, Eurofins, Forte, Galderma, GlaxoSmithKline/ Stiefel, Helsinn, Informa, Johnson & Johnson, LEO Pharma, Menlo, Merck, Micreos, Mylan, National Biological Corporation, National Psoriasis Foundation, Novan, Novartis, Ono, Ortho Dermatology, Pfizer, Qurient, Regeneron, Samsung, Sanofi, Sun Pharma, Teladoc, UCB, UpToDate, Verrica, and vTv Therapeutics; has an ownership interest in Causa Research; and owns stock in Sensal Health. **PREVIOUSLY PRESENTED AT:** Fall Clinical Dermatology (FCD) Conference; October 8–11, 2026; Las Vegas, Nevada, USA.