Durability of Response to the Targeted Oral Peptide Icotrokinra for High-Impact Site Psoriasis: 1-Year ICONIC-TOTAL Findings

Edward Lain,[1] Richard B. Warren,[2] Melinda Gooderham,[3] Robert Bissonnette,[4] Yu-Huei Huang,[5] Julien Ringuet,[6] Matthias Hoffmann,[7] Andreas Pinter,[8] Joseph F. Merola,[9] Jessica H. Rubens,[10] Dorothy Fan,[10] Ming-Chun Hsu,[10] Shu Li,[10] Ya-Wen Yang,[10] Cynthia DeKlotz,[10] Eingun James Song[11]

[1]Austin Institute for Clinical Research, Sanova Dermatology, Austin, TX, USA; [2]Dermatology Centre, Northern Care Alliance NHS Foundation Trust & Division of Musculoskeletal and Dermatological Sciences, Manchester NIHR Biomedical Research Centre, Manchester Academic Health Science Centre, University of Manchester, UK; [3]SKiN Centre for Dermatology, Department of Medicine at Queen's University and Probity Medical Research, Peterborough, ON, Canada; [4]Innovaderm Research, Montréal, QC, Canada; [5]Department of Dermatology, Chang Gung Memorial Hospital and College of Medicine, Chang Gung University, Taoyuan City, Taiwan; [6]Centre de Recherche Dermatologique du Québec Métropolitain, Quebec and McGill University, Montreal, QC, Canada; [7]Dermatology Practice Dr. Matthias Hoffmann, Witten, Germany; [8]University Hospital Frankfurt am Main, Frankfurt am Main, Germany; [9]Department of Dermatology and Department of Medicine, Division of Rheumatology, UT Southwestern Medical Center, Dallas, TX, USA; [10]Johnson & Johnson, Spring House/Horsham, PA, USA; [11]Frontier Dermatology, Mill Creek, WA, USA

Scan the QR code.
The QR code is intended to provide scientific information for individual reference, and the information should not be altered or reproduced in any way.

Key Takeaways

In the phase 3 ICONIC-TOTAL study evaluating the targeted oral peptide ICO in adults and adolescents with PsO and difficult-to-treat, high-impact site involvement:

- ✓ ICO demonstrated high and durable rates of PsO clearance, with rates at W52 of:

	Clear/Almost Clear	Completely Clear
✓ Scalp PsO	72%	57%
✓ Genital PsO	85%	73%
✓ Hand/foot PsO	62%	58%

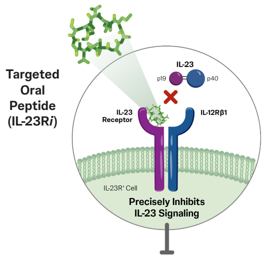
- ✓ ICO provided substantial mean improvement (62%) in nail PsO at W52
- ✓ ICO AE profile was similar to PBO through W16, with stable exposure-adjusted incidence rates through W52
- ✓ No ICO safety signal identified through W52

These findings support the use of ICO for the long-term management of PsO affecting high-impact sites, addressing an important unmet need with a once-daily pill

Background

Icotrokinra for plaque psoriasis (PsO)

- PsO involving difficult-to-treat, high-impact sites can have a substantial negative impact on health-related quality of life[1]
- Per the International Psoriasis Council consensus statement, PsO patients with high-impact site involvement are candidates for systemic therapy, regardless of body surface area (BSA) affected[2]
- Icotrokinra (ICO) is a first-in-class targeted oral peptide that:
  - Selectively binds the interleukin-23 receptor (IL-23R) and precisely inhibits IL-23 pathway signaling[3]
  - Demonstrated significant skin clearance, including in the scalp and genital areas, vs placebo (PBO) at Week (W)16 in participants (pts) with PsO involving high-impact sites, with similar adverse event (AE) rates vs PBO (ICONIC-TOTAL)[4]
  - Demonstrated higher rates of scalp, genital, and hand/foot PsO clearance and substantially improved nail PsO vs PBO at W16 in adults and adolescents with moderate-to-severe plaque PsO (ICONIC-LEAD)[5]



IFN=interferon, IL-12Rβ1=interleukin-12 receptor beta 1, IL-23Ri=IL-23R inhibitor.

Objective

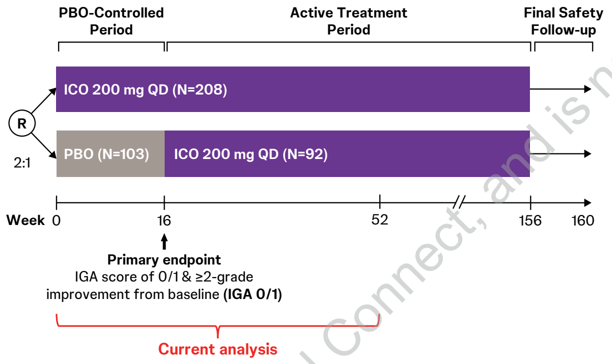
Evaluate the longer-term clinical responses and safety of ICO in adults and adolescents with PsO involving high-impact sites, including the scalp, genitals, hands/feet, and nails, from ICONIC-TOTAL through W52

ICONIC-TOTAL study design

Adults and adolescents with plaque PsO involving high-impact sites (N=311)

Key inclusion criteria

- ≥12 years
- Plaque PsO for ≥26 weeks
- BSA ≥1% and IGA score ≥2
- At least moderate (score ≥3) high-impact PsO involving ≥1 site:
  - **Scalp:** ss-IGA
  - **Genital:** sPGA-G
  - **Hand/foot:** hf-PGA
- Candidate for phototherapy or systemic treatment for plaque PsO and failed ≥1 topical



AE=adverse event, BSA=body surface area, hf-PGA=Physician's Global Assessment of hands and feet, ICO=Icotrokinra, IGA=Investigator's Global Assessment, mNAPSI=modified Nail Psoriasis Severity Index, PBO=placebo, PY=participant-years, QD=once daily, R=Randomization, sPGA-G=static Physician's Global Assessment of Genitalia, ss-IGA=scalp-specific Investigator's Global Assessment.

Outcomes & Analyses

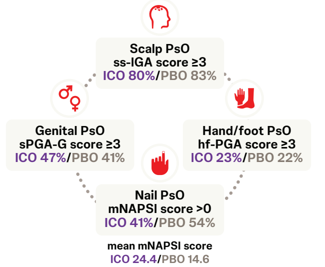
- **Overall PsO:** IGA 0/1 & 0[a,c]
- **Scalp PsO:** ss-IGA 0/1 & 0[a,c]
- **Genital PsO:** sPGA-G 0/1 & 0[a,c]
- **Hand/foot PsO:** hf-PGA 0/1 & 0[a,c]
- **Nail PsO:** mNAPSI % improvement[b,d]
- **AE:** Number (%) of pts and exposure-adjusted incidence rates (/100 PY)

[a]Nonresponder imputation / [b]0% improvement from baseline assigned after participants (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 agent for other reasons.
[c]After accounting for these intercurrent events, pts with missing data were considered nonresponders.
[d]The remaining missing data were not imputed.

Results

Baseline pt and PsO characteristics were generally balanced between groups

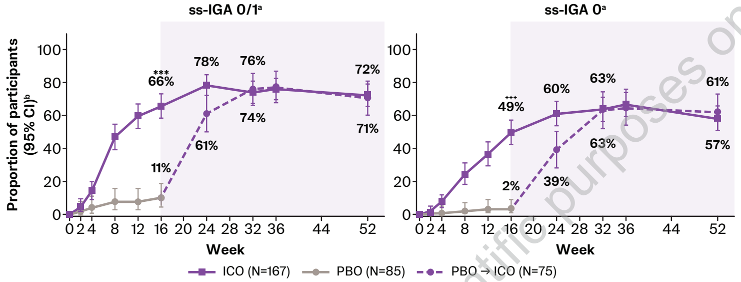
Baseline Characteristics	ICO (N=208)	PBO (N=103)
Demographics		
Age, yrs	45.3 (14.6)	43.5 (13.8)
Female	34%	39%
Race, Asian/Black/White	20% / 1% / 77%	19% / 0% / 80%
BMI, kg/m²	29.0 (6.6)[a]	29.4 (8.1)[a]
Disease Characteristics		
PsO duration, yrs	16.8 (13.3)	15.2 (10.5)
% BSA with PsO	16.6 (13.5)	14.8 (11.7)
IGA score		
Moderate (3)	74%	71%
Severe (4)	22%	21%
PASI (0–72)	14.6 (7.6)	14.0 (7.0)
Prior PsO Treatments		
Phototherapy[b]	43%	31%
Systemic therapy[c]	73%	73%
Biologic therapy[d]	34%	31%



Data shown are mean (SD) unless otherwise noted. PsO involving high-impact sites was not mutually exclusive. [a]ICO: N=203; PBO: N=101. [b]PUVA and UVB. [c]Conventional nonbiologic systemics, novel nonbiologic systemics, 1,25-vitamin D3 and analogues, phototherapy, and biologics. [d]Adalimumab, alefacept, briakinumab, brodalumab, certolizumab pegol, efalizumab, etanercept, guselkumab, infliximab, ixekizumab, natalizumab, risankizumab, secukinumab, tildrakizumab, and ustekinumab. BMI=body mass index, BSA=body surface area, hf-PGA=Physician's Global Assessment of hands and feet, ICO=Icotrokinra, IGA=Investigator's Global Assessment, mNAPSI=modified Nail Psoriasis Severity Index, PASI=Psoriasis Area and Severity Index, PBO=placebo, PsO=psoriasis, PUVA=psoralen plus ultraviolet A, SD=standard deviation, ss-IGA=scalp-specific Investigator's Global Assessment, sPGA-G=static Physician's Global Assessment of Genitalia, UVB=ultraviolet B.

Scalp PsO: ICO demonstrated high rates of clearance that were durable through W52

- After transitioning to ICO, PBO-randomized pts achieved scalp PsO clearance rates comparable to ICO-randomized pts

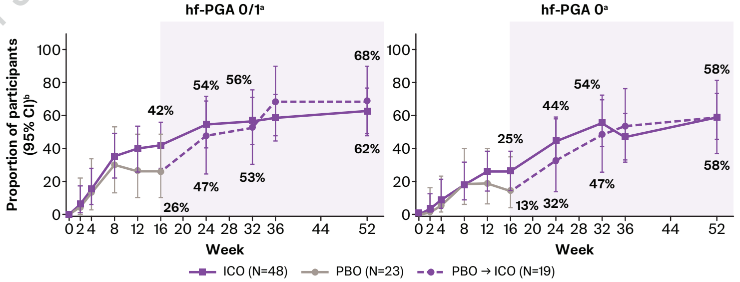


Multiplicity-adjusted ***p<0.001 vs PBO[c] — Nominal +++p<0.001 vs PBO[c,d]

[a]Among pts with a baseline ss-IGA score ≥3. [b]Nonresponder imputation. [c]P-values based on Cochran-Mantel-Haenszel chi-square test stratified by geographic region and BSA category. [d]Endpoint was not included in the hierarchical testing strategy. BSA=body surface area, CI=confidence interval, ICO=Icotrokinra, PBO=placebo, ss-IGA=scalp-specific Investigator's Global Assessment.

Hand/foot PsO: ICO demonstrated increasing rates of clearance through W52

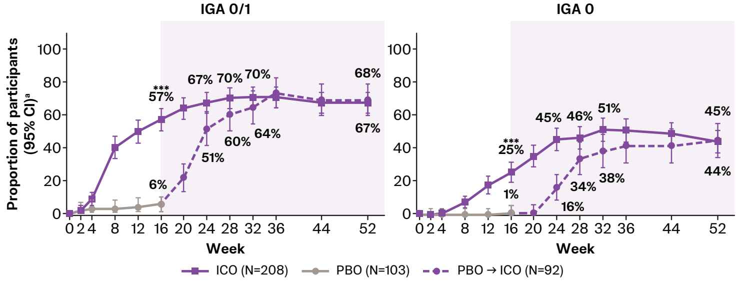
- After transitioning to ICO, PBO-randomized pts achieved hand/foot PsO clearance rates comparable to ICO-randomized pts



[a]Among pts with a baseline hf-PGA score ≥3. [b]Nonresponder imputation. CI=confidence interval, ICO=Icotrokinra, hf-PGA=Physician's Global Assessment of hands and feet, PBO=placebo.

Overall PsO: ICO demonstrated high rates of clearance that were durable through W52

- After transitioning to ICO, PBO-randomized pts achieved skin PsO clearance rates comparable to ICO-randomized pts

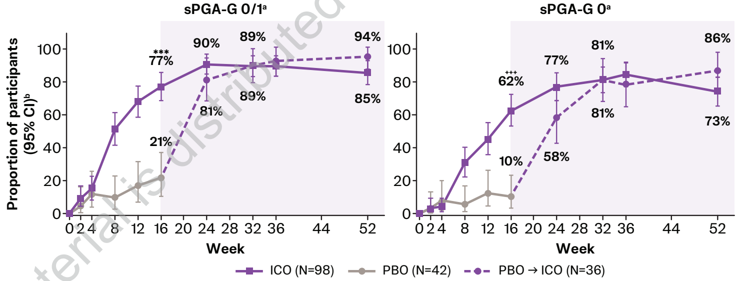


Multiplicity-adjusted ***p<0.001 vs PBO[b]

[a]Nonresponder imputation. [b]P-values based on Cochran-Mantel-Haenszel chi-square test stratified by high-impact site involvement and BSA category. BSA=body surface area, CI=confidence interval, ICO=Icotrokinra, IGA=Investigator's Global Assessment, PBO=placebo.

Genital PsO: ICO demonstrated high rates of clearance that were durable through W52

- After transitioning to ICO, PBO-randomized pts achieved genital PsO clearance rates comparable to ICO-randomized pts

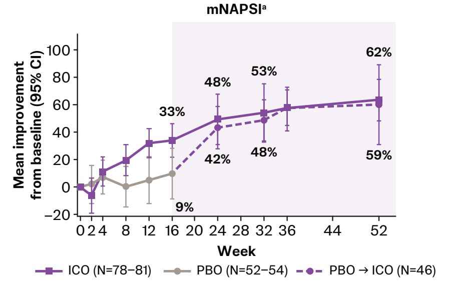


Multiplicity-adjusted ***p<0.001 vs PBO[c] — Nominal +++p<0.001 vs PBO[c,d]

[a]Among pts with a baseline sPGA-G score ≥3. [b]Nonresponder imputation. [c]P-values based on Cochran-Mantel-Haenszel chi-square test stratified BSA category. [d]Endpoint was not included in the hierarchical testing strategy. BSA=body surface area, CI=confidence interval, ICO=Icotrokinra, PBO=placebo, sPGA-G=static Physician's Global Assessment of Genitalia.

Nail PsO: ICO provided substantial mean improvement (62%) at W52

- After transitioning to ICO, PBO-randomized pts achieved improvements in nail PsO comparable to ICO-randomized pts



[a]Among pts with a baseline mNAPSI score >0. CI=confidence interval, ICO=Icotrokinra, mNAPSI=modified Nail Psoriasis Severity Index, PBO=placebo.

Exposure-adjusted AE rates were consistent across groups and study phases

- ICO AE profile was similar to PBO through W16; no ICO safety signal identified through W52

	PBO-controlled (W0–16)		W16–52	Through W52	
AEs Through W52	**ICO (N=208)**	**PBO (N=103)**	**PBO→ICO (N=92)**	**ICO (N=208)**	**ICO Combined[a] (N=300)**
Mean Weeks / Total PY of Follow-Up	16.0 / 63.6	15.6 / 30.8	36.2 / 63.9	49.3 / 196.4	45.3 / 260.2
Any AE	105 (50%)	46 (45%)	51 (55%)	153 (74%)	204 (68%)
Incidence/100 PY (95% CI)[b]	233 (188, 277)	217 (154, 280)	132 (96, 168)	169 (142, 195)	158 (136, 179)
SAE	1 (<1%)	2 (2%)	1 (1%)	6 (3%)	7 (2%)
Incidence/100 PY (95% CI)[b]	2 (0, 5)	7 (0, 16)	2 (0, 5)	3 (1, 6)	3 (1, 5)
AE Leading to D/C	6 (3%)	4 (4%)	0 (0%)	7 (3%)	7 (2%)
Incidence/100 PY (95% CI)[c]	10 (4, 21)	13 (4, 34)	0 (0, 5)	4 (1, 7)	3 (1, 6)
Infection	59 (28%)	23 (22%)	39 (42%)	106 (51%)	145 (48%)
Incidence/100 PY (95% CI)[b]	110 (82, 138)	88 (52, 124)	81 (56, 106)	81 (66, 96)	81 (68, 94)
Serious Infection	0 (0%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)
Incidence/100 PY (95% CI)[c]	0 (0, 5)	3 (<1, 18)	0 (0, 5)	0 (0, 2)	0 (0, 1)
GI AE	15 (7%)	8 (8%)	7 (8%)	21 (10%)	28 (9%)
Incidence/100 PY (95% CI)[b]	25 (12, 37)	27 (8, 46)	11 (3, 20)	12 (7, 17)	12 (7, 16)
Malignancy[d]	1 (<1%)	0 (0%)	0 (0%)	2 (1%)	2 (1%)
Incidence/100 PY (95% CI)[c]	2 (<1, 9)	0 (0, 10)	0 (0, 5)	1 (<1, 4)	1 (<1, 3)

Data shown are n (%) unless otherwise noted. [a]Includes data for ICO-randomized pts through W52 and for PBO-to-ICO pts from W16 through W52. [b]CIs were based on a Wald statistic using the normal assumption. [c]CIs were based on an exact method assuming that the observed number of events follows a Poisson distribution. [d]Includes chronic lymphocytic leukaemia and malignant melanoma in situ. AE=adverse event, CI=confidence interval, D/C=discontinuation, GI=gastrointestinal, ICO=Icotrokinra, PBO=placebo, SAE=serious AE.

PRESENTED AT: Winter Clinical-Hawaii 2026; Maui, Hawaii, USA; January 16–21, 2026.
REFERENCES: 1. Merola JF. *Dermatol Ther.* 2018;31:e12589. **2.** Strober B. *J Am Acad Dermatol.* 2020;82:117–22. **3.** Fourie AM. *Sci Rep.* 2024;14:17515. **4.** Gooderham MJ. SID Annual Meeting; May 7–10, 2025; San Diego, CA, USA. **5.** Soung J. Presented at: AAD Innovation Academy; July 12, 2025; Chicago, IL, USA.
ACKNOWLEDGMENTS: Medical writing support was provided by JSS Medical Research under the direction of the authors in accordance with Good Publication Practice guidelines (*Ann Intern Med.* 2022;175:1298–1304). This presentation was sponsored by Johnson & Johnson. **DISCLOSURES: EL:** Speaker, consultant, advisory board member, or principal investigator for AbbVie, Aslan Pharmaceuticals, Biofrontera, Caliway, Cassiopea, Castle Biosciences, Concert Pharmaceuticals, Celldex Therapeutics, Eli Lilly, Evoimmune, Galderma, Incyte, Johnson & Johnson, L'Oreal, Nielsen BioSciences, Peregrine Ophthalmic, Pfizer, Regeneron, RegenX Science, Sanofi, Symatese, Takeda, Teoxane, UCB, Verademics, and Vyne. **RBW:** Consultant and/or speaker for AbbVie, Almirall, Alumis, Amgen, Apogee, Arena, Astellas, Avillion, Biogen, Boehringer Ingelheim, Bristol Myers Squibb, Celgene, DICE Therapeutics, Eli Lilly, Galderma, GSK, Johnson & Johnson, LEO Pharma, Meiji Pharma, Nektar, Novartis, Pfizer, RAPT Pharmaceuticals, Sanofi, Sitryx, Sun Pharma, UCB, and UNION; received research grants from AbbVie, Almirall, Amgen, Celgene, Eli Lilly, Johnson & Johnson, LEO Pharma, Novartis, Pfizer, and UCB. **MG:** Speaker, investigator or advisory board member for AbbVie, Acelyrin, Alumis, Amgen, Akros, AnaptysBio, Apogee, Arcutis, Arena, Aslan, Bausch Health, Boehringer Ingelheim, Bristol Myers Squibb, Coherus, Dermira, Dermavant, Eli Lilly, Galderma, GlaxoSmithKline, Incyte, InMagene, Johnson & Johnson, JAMP Pharma, Kyowa Kirin, LEO, Medimmune, Merck, Moonlake, Nimbus, Novartis, Pfizer, Regeneron, Reistone, Sanofi Genzyme, Sun, Tarsus, Takeda, Union, UCB, and Vyne. **RB:** 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, Takeda, UCB, VentyxBio, Vyne, Xencor, Zai Lab, and Zurabio; employee and shareholder of Innovaderm Research. **Y-HH:** Conducted clinical trials for or received honoraria as a consultant for AbbVie, Bristol Myers Squibb, Celgene, Johnson & Johnson, Novartis, and Pfizer. **JR:** Consultant and/or speaker for Abbvie, Amgen, Apogee, Arcutis, Bausch Health, Boehringer Ingelheim, Bristol Myers Squibb, Eli Lilly, Galderma, Incyte, Johnson & Johnson, JAMP, Leo Pharma, L'Oréal, NKS Health, Novartis, Organon, Pfizer, Sandoz, Sanofi Genzyme, Sun Pharma, UCB; participated as an Investigator in clinical trials for AbbVie, Amgen, Apogee, Alumis, Aristea, ASLAN Therapeutics, Bristol Myers Squibb, Celgene, Concert Pharmaceuticals, CorEvitas, DICE therapeutics, Eli Lilly, Incyte, Innovaderm, Johnson & Johnson, Kyowa Kirin, Leo Pharma, Merck, Novartis, Pfizer, Sanofi Genzyme, Sun Pharma, UCB. **MH:** Advisory board member, consultant, speaker and/or investigator for and/or received honoraria and/or grants from AbbVie, Almirall, Biofrontera, Bristol Myers Squibb, Dermapharm, Dermasence, Forward, Galderma, Incyte, Johnson & Johnson, Kiniksa, Leo Pharma, Lilly, L'Oréal, MSD, Nektar Therapeutics, Novartis, Pierre Fabre, Pfizer, Sanofi, Schering-Plough, Smerud Medical Research, Stallergenes Greer, Viatris, and UCB. **AP:** Advisor and/or received speaker's honoraria and/or received grants and/or participated in clinical trials for AbbVie, Almirall Hermal, Amgen, Biogen Idec, BioNTech, Boehringer Ingelheim, Celgene, Celltrion, Eli Lilly, Galderma, GSK, Hexal, Johnson & Johnson, Klinge Pharma, LEO Pharma, MC2, Medac, Merck Serono, Mitsubishi, MSD, Novartis, Pascoe, Pfizer, Regeneron, Roche, Sandoz Biopharmaceuticals, Sanofi Genzyme, Schering-Plough, Tigercat Pharma, UCB, and Zuellig Pharma. **JFM:** 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. **JHR, DF, M-CH, SL, Y-WY,** and **CD:** Employees of Johnson & Johnson; may own stock/stock options in Johnson & Johnson. **EJS:** Investigator, consultant, and/or speaker for AbbVie, Acelyrin, Alphyn, Alumis, Amgen, Apogee, Arcutis, ASLAN, Boehringer Ingelheim, Bristol Myers Squibb, CorEvitas, Dermavant, DermBiont, Eli Lilly, Galderma, Incyte, Johnson & Johnson, LEO Pharma, MoonLake, Novartis, Pfizer, Regeneron, Sanofi, Sun Pharma, TARGET PharmaSolutions, TIMBER, and UCB. **PREVIOUSLY PRESENTED AT:** Fall Clinical Dermatology Conference; Las Vegas, NV, USA; October 23–26, 2025.

materials distributed for scientific purposes on J&J Medical Connect, and is not for promotional use