

**European Union Risk Management Plan
ICOTYDE (icotrokinra)**

Details of this RMP Submission

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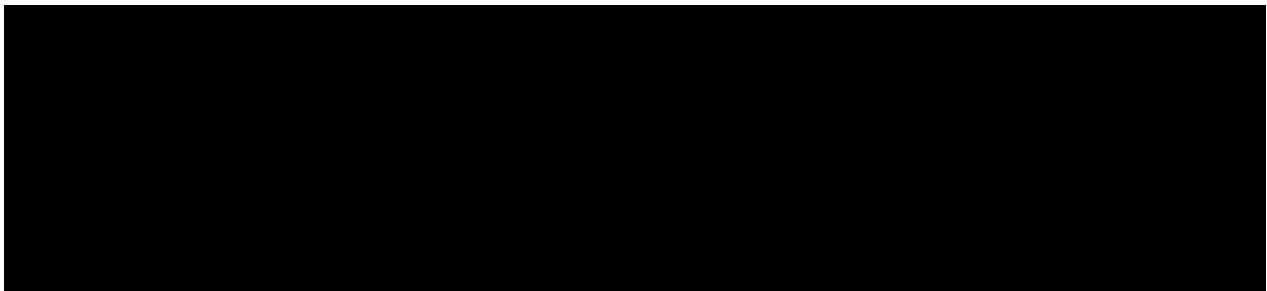
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QPPV details

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ABBREVIATIONS

ATC	anatomical therapeutic chemical
AUC	area under the concentration-time curve
BID	bis in die, twice daily
BSA	body surface area
CI	confidence interval
CV	cardiovascular
DMARD	disease-modifying antirheumatic drug
EEA	European Economic Area
eGFR	estimated glomerular filtration rate
EMA	European Medicines Agency
EPAR	European Public Assessment Report
GBD	Global Burden of Disease
HRQoL	health-related quality of life
IHME	Institute for Health Metrics and Evaluation
IL	interleukin
IL-23R	interleukin-23 receptor
INN	international nonproprietary name
LTE	long-term extension
MRHD	maximum recommended human dose
NOAEL	no-observed-adverse-effect level
OR	odds ratio
PDE4	phosphodiesterase 4
PL	Package Leaflet
PsA	psoriatic arthritis
PSUR	periodic safety update report
PY	person-years
QD	quaque die, once daily
RMP	risk management plan
SmPC	Summary of Product Characteristics
UI	uncertainty interval
UK	United Kingdom
US	United States

PART I: PRODUCT(S) OVERVIEW**Table Part I.1: Product(s) Overview**

Active substance(s) (INN or common name)	Icotrokinra (also known as JNJ-77242113)	
Pharmacotherapeutic group(s) (ATC Code)	Not yet assigned	
Marketing Authorization Applicant	Janssen Research & Development	
Medicinal products to which the RMP refers	1	
Invented name(s) in the EEA Marketing authorization procedure	ICOTYDE®	
	Centralized	
Brief description of the product	Chemical class: IL-23R antagonist. Summary of mode of action: Icotrokinra binds selectively to the IL-23R with high affinity and competitively antagonizes the binding of IL-23. Icotrokinra inhibits the IL-23/IL-23R-dependent release of proinflammatory cytokines. Important information about its composition: Icotrokinra is a synthetic peptide comprising 13 amino acids. It is formulated as a film-coated tablet that is manufactured and controlled by a continuous direct compression process.	
Reference to the Product Information	Module 1.3.1 Summary Product Characteristics (SmPC), Labeling and Package Leaflet	
Indication(s) in the EEA	Current: Treatment of moderate to severe plaque psoriasis in adults, and adolescents 12 years of age and older and weighing at least 40 kg, who are candidates for systemic therapy.	
	Proposed: Not applicable	
Dosage(s) in the EEA	Current: 200 mg orally once daily.	
	Proposed: Not applicable	
Pharmaceutical form(s) and strength(s)	Current: 200-mg film-coated tablet.	
	Proposed: Not applicable	
Is/will the product be subject to additional monitoring in the EU?	☒ Yes	☐ No

PART II: SAFETY SPECIFICATION

Module SI: Epidemiology of the Indication(s) and Target Population(s)

Indication: Plaque Psoriasis

Psoriasis is a chronic, immunologically mediated, inflammatory skin disease of unknown etiology that affects up to 4% of the population (Armstrong 2020; Parisi 2020). The most common type of psoriasis is plaque psoriasis, which accounts for approximately 90% of cases (Boehncke 2015) and is characterized by well-demarcated, erythematous, pruritic plaques that are covered in silvery scales secondary to uncontrolled proliferation and dysfunctional differentiation of skin epithelial cells (Armstrong 2022; Strober 2020; Strober 2025). Areas of the body that are frequently involved and considered difficult to treat include the scalp (45%-56%), genitalia (29%-63%), nails (50%), and, less frequently, the hands and feet (12%-16%) (Armstrong 2022; Jiaravuthisan 2007; Strober 2020; Strober 2025). Approximately 30% of patients with psoriasis also develop PsA (Boehncke 2015).

Adult Population

Incidence

The GBD study estimated the global age-standardized incidence rate of psoriasis in 2019 as 67.9 per 100,000 population (95% UI 59.2-77.3) aged 15 years and older (Wang 2024).

Europe

Parisi (2020) performed a systematic review of the literature and found that the incidence of psoriasis across all ages ranged from 31.4 per 100,000 PY in Russia to 521.1 per 100,000 PY in Germany. In an Italian national primary care database study that included adults with a first diagnosis of psoriasis between 2001 and 2005, the incidence of psoriasis ranged from 2.30 to 3.21 cases per 1,000 PY, with a slightly higher incidence in males (2.54-3.57 cases per 1,000 PY) than in females (2.07-2.91 cases per 1,000 PY) (Vena 2010). In the United Kingdom, the incidence of psoriasis using Clinical Practice Research Datalink data was reported as 129 per 100,000 persons in 2013 (Springate 2017). A nationwide study in Denmark that followed the entire adult population from 2003 to 2012 reported an incidence rate of 151.21 per 100,000 PY for 2012 (Egeberg 2017).

North America

In the United States, a retrospective cohort analysis of psoriasis patients aged 18 years or older who were identified through electronic health records between 2014 and 2018 reported an overall standardized incidence rate of psoriasis of 63.8 per 100,000 PY (95% CI 61.8-65.8) (Burshtein 2021). In Canada, the age-standardized incidence rate of psoriasis was 225 per 100,000 population in 2017 (95% UI 217-233) (Bridgman 2020).

Other Regions

The estimated incidence of psoriasis in 2022 for other regions is presented below (IHME 2024).

Location	Incidence per 100,000 Population	95% Confidence Interval
Southern Latin America	80.68	77.52-84.03
Latin America and Caribbean	76.02	73.52-78.53
Southeast Asia, East Asia, and Oceania	69.93	67.77-72.14
North Africa and Middle East	63.99	61.85-66.16
South Asia	49.74	48.12-51.32
Sub-Saharan Africa	30.70	29.57-31.67

Prevalence

According to the GBD study, the global age-standardized prevalence rate of psoriasis in 2019 was 639.0 per 100,000 population (95% CI 592.7-686.7) aged 15 years and older (Wang 2024).

Europe

A systematic review of the literature by Parisi (2020) reported the prevalence of psoriasis in the overall population in 2017 as 1.52% (95% UI 0.87-2.74) in Western Europe, 1.45% (95% UI 0.49-4.08) in Central Europe, and 0.47% (95% UI 0.13-1.75) in Eastern Europe.

In Norway, the prevalence of psoriasis varied from 3.8% to 4.6% from 2015 to 2020 (Solberg 2023). In Germany, the prevalence of psoriasis ranged from 2.46% to 2.51% in 2019 (Hagenström 2024).

North America

Findings from a cross-sectional analysis of a health records database in the United States which gathered data from 2019 to 2020 reported a 1-year standardized prevalence of psoriasis among adults aged 18 years and older of 1.39% (95% CI 1.38-1.40) (Nazir 2022). Another national US study that used data from the National Health and Nutrition Examination Survey reported an overall prevalence of psoriasis of 2.7% in 2014 (Semenov 2021). According to the GBD study, the prevalence of psoriasis in Canada in 2017 was 3,140 per 100,000 population (95% UI 3,030-3,249) (Bridgman 2020).

Other Regions

The estimated prevalence of psoriasis in 2022 for other regions is presented below (IHME 2024).

Location	Prevalence per 100,000 Population	95% Confidence Interval
Southern Latin America	675.54	651.48-700.43
Latin America and Caribbean	623.77	602.62-644.39
Southeast Asia, East Asia, and Oceania	569.64	549.71-589.28
North Africa and Middle East	499.26	481.02-517.29
South Asia	360.41	348.65-372.35
Sub-Saharan Africa	225.00	217.49-232.87

Demographics of the Population in Psoriasis and Risk Factors for the Disease

Psoriasis appears to occur most frequently in populations of Northern Europe and is less common in populations of Eastern Asia. A weak correlation between geographic latitude and psoriasis prevalence has been reported (World Health Organization Global Report on Psoriasis 2016). Estimates of psoriasis prevalence from nationally representative data in the United States which stratified the sample by race/ethnicity among those aged 20 to 59 years were highest in Caucasians at 3.6%, followed by African Americans at 1.9%, Hispanics at 1.6%, and other races/ethnicities at 1.4% (Rachakonda 2014). Published studies differ regarding variation in psoriasis incidence by sex (Parisi 2020), with some studies reporting a slightly higher incidence in males (Vena 2010).

Potential under-reporting, selection bias, and undiagnosed psoriasis in non-white individuals due to barriers to care and decreased healthcare utilization may result in underestimated prevalence in non-white individuals (Rao 2023; Yadav 2022).

Some studies have reported on the clinical variation of psoriasis in patients of color, specifically African Americans, who may present with a different set of defining characteristics, including less conspicuous erythema that appears violaceous or hyperpigmented, making it harder to appreciate areas of active inflammation compared with lighter-skinned individuals. Abrouk (2017) reported that Asians have greater BSA involvement at initial presentation compared with whites and that both Asians and Hispanics had significantly more severe psoriasis than whites. A survey of US psoriasis experts found that 66% of physicians reported clinical differences in psoriasis between African American patients and Caucasian patients, with less erythema, increased risk of pigmentation, thicker plaques, more scaling, and greater BSA involvement in African American patients (McMichael 2012).

Parisi (2020) reported that the incidence of psoriasis was higher in adults than in children, varying from 30.3 per 100,000 PY (95% CI 26.6-34.1) in adults in Taiwan to 321.0 per 100,000 PY in adults in Italy. In children, the incidence of psoriasis increased with age, from 13.5 per 100,000 PY in children 3 years of age and younger to 53.1 per 100,000 PY in children 14 to 18 years of age. In a systematic review of the published literature through October 2019, Iskandar (2021) reported a bimodal age pattern in the onset of psoriasis, with peaks at 30 to 39 and at 60 to 69 years of age. A study by Wang (2024) that examined data from the GBD study reported that in 2019, the incidence and prevalence of psoriasis were highest in adults aged 40 to 64 years.

Genetics may play a key role in the development of psoriasis, with a higher prevalence of psoriasis among first-degree relatives of psoriasis patients than in the general population (Eder 2015). Genetic studies have suggested a strong association between psoriasis and human leukocyte antigen class I genes, located in the major histocompatibility complex. Psoriasis has also been associated with higher body mass index, lower physical activity, lower educational level, and smoking (Danielsen 2013).

Main Existing Treatment Options

Management of adult patients with plaque psoriasis traditionally includes topical and conventional oral systemic therapies, with or without phototherapy, before advancing to biologic agents or novel oral systemic therapies.

Corticosteroids, vitamin D analogs, and calcineurin inhibitors are first-line topical agents for the treatment of plaque psoriasis in patients of all ages.

Phototherapy (broad- or narrow-band ultraviolet B light, psoralen plus ultraviolet light) may be used to treat patients with plaque psoriasis that cannot be controlled with topical treatments alone.

Conventional oral systemic therapies such as cyclosporine, methotrexate, oral retinoids, and fumarates are available, but their use is limited by varying efficacy and dose-limiting toxicities.

Biologic therapies that inhibit tumor necrosis factor- α (infliximab, etanercept, adalimumab, certolizumab pegol), IL-12/IL-23 (ustekinumab), IL-17 (secukinumab, ixekizumab, brodalumab, bimekizumab), and IL-23 p19 ligand (guselkumab, tildrakizumab, and risankizumab) target specific immunologic factors in patients with moderate to severe plaque psoriasis and are typically reserved as second- or third-line treatment of plaque psoriasis in adults.

Novel oral small-molecule systemic therapies for the treatment of moderate to severe plaque psoriasis include the PDE4 inhibitor apremilast and the tyrosine kinase 2 inhibitor deucravacitinib. Apremilast is also approved for the treatment of mild plaque psoriasis in the United States.

Natural History of Plaque Psoriasis in the Untreated Adult Population, Including Mortality and Morbidity

Individuals with plaque psoriasis may experience pain, itching, and bleeding from psoriatic lesions. These physical discomforts, combined with the potential psychological effects of the disease, may interfere with daily activities and negatively impact an individual's HRQoL (Armstrong 2025). The decrease in HRQoL is associated with both the BSA affected and the location of lesions, particularly the scalp, genitals, and hands and feet (palmoplantar) (Merola 2018).

Disease severity may be associated with an increased prevalence of certain comorbidities, such as diabetes and CV disease. Patients with severe disease are at greater risk of developing renal disease (OR=1.83) and rheumatologic disease (OR=2.89) compared to those with mild disease (ORs of 0.97 and 2.01 for renal and rheumatologic disease, respectively) (Yeung 2013). Individuals with psoriasis have an increased risk of CV disease compared to those without psoriasis, with severe

psoriasis being associated with the highest CV risk compared to controls. The outcomes associated with this increased risk include stroke, myocardial infarction, and CV death (Masson 2020; Samarasekera 2013, Yim 2017).

Mortality

A meta-analysis of 12 studies reporting all-cause or cause-specific mortality risk estimates in psoriasis patients compared with the general population or subjects free of psoriasis found that the pooled relative risks for all-cause mortality were 1.21 (95% CI 1.14-1.28) in psoriasis, 1.13 (95% CI 1.09-1.16) in mild psoriasis, and 1.52 (95% CI 1.35-1.71) in severe psoriasis. The pooled relative risk for CV mortality was the most prominent cause-specific mortality risk and was estimated at 1.15 (95% CI 1.09-1.21) in psoriasis (Dhana 2019).

In the United States, psoriasis has been associated with an increased mortality risk, with a hazard ratio of 1.99 (95% CI 1.01-3.93) (Semenov 2021).

The increased mortality risk associated with severe psoriasis was also observed in a cohort study performed in a large UK medical records database (The Health Improvement Network, THIN), which included data from 1994 to 2010 (Ogdie 2014). Among patients with psoriasis, the overall mortality rate (deaths per 1,000 PY) was 12.12. Among patients with psoriasis who were prescribed DMARDs, indicating more severe psoriasis, the mortality rate was 22.19. Among patients with psoriasis who were not prescribed DMARDs, the mortality rate was 11.92.

Important Comorbidities

Comorbidities that frequently occur in patients with plaque psoriasis include metabolic disorders, obesity, hypertension, type 2 diabetes, non-alcoholic fatty liver disease, cardiac disorders, other autoimmune diseases, depression, anxiety, suicidal ideation and behavior, non-melanoma skin cancers, and PsA (Boehncke 2015; Hedemann 2022; Pouplard 2013; Yamazaki 2021).

Pediatric Population

The literature on psoriasis in adolescents is limited; therefore, estimates of incidence and prevalence specific to the pediatric population aged 12 to 17 years may not be available.

Incidence

In 2022, the estimated global incidence of psoriasis in individuals less than 20 years of age was 34.85 per 100,000 population (95% CI 32.57-37.00) (IHME 2024). Up to 84% of children with psoriasis have plaque psoriasis (Lewkowicz 2004).

Europe

In 2022, the estimated incidence of psoriasis in individuals less than 20 years of age was 66.13 per 100,000 population in the European Union (95% CI 62.15-70.14) (IHME 2024).

North America

In 2022, the estimated incidence of psoriasis in individuals less than 20 years of age was 66.62 (95% CI 63.07-70.40) and 66.56 (95% CI 62.19-70.73) per 100,000 population in the United States and Canada, respectively (IHME 2024).

Other Regions

The estimated incidence of psoriasis in individuals under 20 years of age in other regions in 2022 is presented below (IHME 2024).

Location	Incidence per 100,000 Population	95% Confidence Interval
Latin America and Caribbean	51.49	47.99-54.78
Southern Latin America	47.78	44.21-51.64
Southeast Asia, East Asia, and Oceania	33.56	31.28-35.71
North Africa and Middle East	33.00	30.62-35.32
South Asia	32.97	30.83-35.03
Sub-Saharan Africa	22.49	20.96-23.92

Prevalence

In 2022, the estimated global prevalence of psoriasis in individuals less than 20 years of age was 209.36 per 100,000 population (95% CI 197.58-221.75) (IHME 2024). The available prevalence data, summarized below, suggests that plaque psoriasis is rare below 9 years of age, with prevalence varying from 0% in Norway to 0.55% in the United Kingdom, and extremely rare below 6 years of age (Parisi 2013).

Europe

The highest reported prevalence of psoriasis in individuals aged 10 to 19 years are from European studies, particularly Italy (2.1%), Germany (1.3%), and the United Kingdom (1.3%) (Burden-Teh 2016). The IHME estimated the prevalence of psoriasis in the European Union in individuals less than 20 years of age as 415.38 per 100,000 population (95% CI 393.47-440.28) in 2022 (IHME 2024). Parisi (2020) reported the prevalence of psoriasis in children less than 18 years of age in Western Europe as 0.21%.

North America

In 2022, the estimated prevalence of psoriasis in individuals under 20 years of age was 453.48 (95% CI 433.18-474.01) and 66.56 per 100,000 population (95% CI 62.19-70.73) in the United States and Canada, respectively (IHME 2024).

Other Regions

In 2015, the estimated prevalence of psoriasis in Korea was 2.0% for individuals under 10 years of age and 2.9% for individuals aged between 10 and 19 years (Han 2018).

The estimated prevalence of psoriasis for individuals under 20 years of age in other regions in 2022 is presented below (IHME 2024).

Location	Prevalence per 100,000 Population	95% Confidence Interval
Latin America and Caribbean	328.93	308.42-349.47
Southern Latin America	285.21	265.49-304.82
Southeast Asia, East Asia, and Oceania	199.19	187.33-211.54
South Asia	194.30	183.23-206.35
North Africa and Middle East	185.72	174.77-197.28
Sub-Saharan Africa	135.22	127.35-143.63

Demographics of the Population in Pediatric Plaque Psoriasis and Risk Factors for the Disease

The median onset of childhood psoriasis is between 7 and 10 years of age (Eichenfield 2018). The table below displays the age- and sex-specific annual incidence of psoriasis in children per 100,000 population using data from a population-based cohort in the United States from 1970 to 1990 (Tollefson 2010). A rapid increase was observed in children of both sexes up to 7 years of age, with the incidence remaining relatively flat thereafter.

Age Group (Years)	Male	Female	Total
0-3	13.7	13.2	13.5
4-7	44.1	40.2	42.2
8-10	33.2	55.7	44.0
11-13	54.6	49.6	52.2
14-17	44.7	61.9	53.1
Total	37.9	43.9	40.8

A US claims-based study reported that among children with psoriasis under 18 years of age, 55.7% were between 12 and 17 years old, 40% were between 4 and 11 years old, and 4.3% were less than 3 years old (Paller 2018).

A German health insurance database study reported the prevalence of psoriasis in children and adolescents as 0.45% (95% CI 0.42-0.47) in 2009, with prevalence increasing with age from 0.13% between the ages of 0 and 2 years to 0.67% between the ages of 14 and 18 years (Augustin 2015).

In a review of the published literature on pediatric psoriasis, Relvas (2017) reported that Caucasian children are more affected than children of other ethnicities and have an earlier mean age of onset.

Many of the risk factors for psoriasis in adults apply to the pediatric population. Genetics play a key role in pediatric psoriasis, with many children with psoriasis having a first-degree relative with the disease (Tollefson 2014). In a Turkish case-control study of environmental risk factors, high body mass index, environmental tobacco smoke exposure at home, and stressful life events appeared to be associated with pediatric psoriasis (Ozden 2011). Other risk factors include infection, stress (usually emotional or psychological), a history of trauma, and obesity (Burden-Teh 2016; Ozden 2011).

Main Existing Treatment Options

The traditional treatment paradigm for pediatric plaque psoriasis follows a similar stepwise approach as for adult plaque psoriasis, starting with topical agents, followed by phototherapy, and then by systemic agents, including conventional oral medications and biologics (Bhutani 2012; Busch 2012; Menter 2019; Menter 2020).

Topical therapies such as corticosteroids, vitamin D analogs, and calcineurin inhibitors are first-line agents for the treatment of plaque psoriasis in patients of all ages.

Phototherapy (broad- or narrow-band ultraviolet B light, psoralen plus ultraviolet light) may be used to treat patients with plaque psoriasis that cannot be controlled with topical treatments alone.

The use of conventional oral therapies, including cyclosporine, methotrexate, and acitretin, may be limited due to varying efficacy and dose-limiting toxicities.

Biologics (etanercept, ustekinumab, adalimumab, secukinumab, and ixekizumab) are typically second- or third-line treatment options for pediatric patients with moderate to severe plaque psoriasis.

Novel oral small-molecule therapy for the treatment of plaque psoriasis in adolescents includes the PDE4 inhibitor apremilast.

Natural History of Plaque Psoriasis in the Untreated Pediatric Population, Including Mortality and Morbidity

Psoriasis begins in childhood in almost one-third of cases. The clinical manifestations of plaque psoriasis in patients with pediatric-onset disease and those with adult- or late-onset disease are generally similar: the scalp, elbows, knees, and genitalia are the most frequently involved areas of the body, and lesions are usually symmetrically distributed and not clinically distinguishable (Bronckers 2015; Lewkowicz 2004; Silverberg 2009). In children, the scalp is often the site of first presentation. Lesions may be thinner and smaller in children. In younger children, lesions tend to develop more on the scalp, face, and anogenital region; in older children and adolescents, involvement of the scalp and flexural regions, such as the elbows and knees, is more common (Bronckers 2015; Do 2024; Morita 2024). In addition to shared clinical symptoms, adult and pediatric plaque psoriasis share similar histological features, genetic factors, and treatment options (Bronckers 2015).

Important Comorbidities

Comorbidities that occur in pediatric patients with psoriasis include obesity, diabetes mellitus, allergic rhinitis, bronchial asthma, hyperlipidemia, arterial hypertension, and psychiatric disorders such as depression and anxiety (Augustin 2015; Kimball 2012).

PART II: SAFETY SPECIFICATION

Module SII: Nonclinical Part of the Safety Specification

Key Safety Findings From Nonclinical Studies	Relevance to Human Usage
<u>Toxicity</u>	
Single and repeat-dose toxicity	
Icotrokinra was well tolerated in rats following daily oral dosing for 2 weeks at doses up to 600 mg/kg, for 6 weeks at doses up to 70 mg/kg, and for 6 months at doses up to 20 mg/kg. In monkeys, daily oral dosing for 2 weeks at doses up to 300 mg/kg, for 17 weeks at doses up to 600 mg/kg, and for 9 months at doses up to 200 mg/kg was also well tolerated. No adverse findings were noted. The NOAEL in each study was typically the highest dose level tested.	Nonclinical data do not indicate a safety concern for humans.
Reproductive and developmental toxicity	
Icotrokinra was evaluated in rats and rabbits for effects on embryo-fetal development and in rats for effects on male and female fertility and early development. In rats, no adverse findings on embryo-fetal development or fertility parameters were observed. In rabbits, maternal body weight loss, low food consumption, and pregnancy losses were observed at 500 mg/kg/day (95 times the MRHD based on unbound AUC comparison). At the NOAEL of 500 mg/kg for developmental toxicity, maternal exposure was 95 times the MRHD (based on unbound AUC comparison). In a pre- and post-natal development study in rats, there were no adverse changes in pre-natal and post-natal development, including sexual maturation, neurobehavioral assessments, and reproductive performance, at doses up to 200 mg/kg/day (127 times the MRHD based on total AUC comparison).	Based on the nonclinical data, icotrokinra is not expected to affect human fertility or pre- and post-natal development or cause embryofetal toxicity.
Genotoxicity	
Icotrokinra was tested in a standard battery of genotoxicity studies: an Ames assay, an in vitro chromosomal aberration assay, and a combined in vivo micronucleus and comet assay. No evidence of genotoxicity was identified.	Icotrokinra is not expected to be genotoxic in humans.

Key Safety Findings From Nonclinical Studies	Relevance to Human Usage
Carcinogenicity	
No evidence of tumorigenicity was identified in the 6-month transgenic mice carcinogenicity study or the 2-year rat carcinogenicity study.	Nonclinical data do not suggest a risk for carcinogenicity in humans.
<u>Safety pharmacology</u>	
Cardiovascular system (including potential effect on QT interval)	
In a CV safety study in telemetered monkeys and in CV assessments in repeated-dose studies in monkeys, no effects on CV safety were identified. No risk was identified in an in vitro human ether-à-go-go-related gene assay.	Nonclinical data do not suggest a risk for CV toxicity in humans.
Nervous system	
In a modified Irwin neurobehavioral study in rats and in repeated-dose studies in rats and monkeys, no adverse changes suggestive of nervous system toxicity were observed.	Nonclinical data do not suggest a risk for nervous system toxicity in humans.

PART II: SAFETY SPECIFICATION

Module SIII: Clinical Trial Exposure

SIII.1. Overview of Clinical Trials in the RMP

Data from the following clinical trials are included in this RMP:

Plaque Psoriasis

- **77242113PSO2001 (PSO2001):** A Phase 2b multicenter, randomized, placebo-controlled, dose-ranging trial to evaluate the efficacy and safety of icotrokinra for the treatment of adult participants with moderate to severe plaque psoriasis. Participants received either placebo or icotrokinra 25 mg QD, 50 mg QD, 100 mg QD, 25 mg BID, or 100 mg BID, for a treatment duration of 16 weeks.
- **77242113PSO2002 (PSO2002):** A Phase 2b multicenter, LTE, dose-ranging trial to evaluate the efficacy and safety of icotrokinra for the treatment of adult participants with moderate to severe plaque psoriasis. Eligible participants from Trial PSO2001 were given the option to enroll in LTE Trial PSO2002. All participants who were randomized to an active icotrokinra dose regimen (25 mg QD, 50 mg QD, 100 mg QD, 25 mg BID, or 100 mg BID) in Trial PSO2001 continued to receive the same dosing regimen of icotrokinra in Trial PSO2002 in a blinded manner. Participants who were randomized to placebo in Trial PSO2001 received icotrokinra 100 mg QD starting at LTE Week 0. Treatment duration was 36 weeks.
- **77242113PSO3001 (PSO3001):** A Phase 3 multicenter, randomized, double-blind, placebo-controlled trial to evaluate the efficacy and safety of icotrokinra for the treatment of adult and adolescent participants 12 years of age and older with moderate to severe plaque psoriasis with randomized withdrawal and retreatment. Adult participants received either icotrokinra 200 mg QD from Week 0 to Week 24, after which they were re-randomized to placebo or continued on icotrokinra from Week 24 to Week 52 (depending on response) and thereafter received icotrokinra from Week 52 to Week 156, or they received placebo from Week 0 to Week 16 followed by a crossover to icotrokinra from Week 16 to Week 156. Adolescent participants received either icotrokinra 200 mg QD from Week 0 to Week 156 or placebo from Week 0 to Week 16 followed by a crossover to icotrokinra from Week 16 to Week 156.
- **77242113PSO3002 (PSO3002):** A Phase 3 multicenter, randomized, double-blind, placebo-controlled and deucravacitinib-active-comparator-controlled trial to evaluate the efficacy and safety of icotrokinra for the treatment of adult participants with moderate to severe plaque psoriasis. Participants were randomized to receive either icotrokinra 200 mg QD from Week 0 to Week 156; placebo from Week 0 to Week 16 followed by a crossover to icotrokinra from Week 16 to Week 156; or deucravacitinib from Week 0 to Week 24 followed by a crossover to icotrokinra from Week 24 to Week 156.
- **77242113PSO3003 (PSO3003):** A Phase 3 multicenter, randomized, double-blind, placebo-controlled trial to evaluate the efficacy and safety of icotrokinra for the treatment of adult and adolescent participants 12 years of age and older with plaque psoriasis involving special areas (scalp, genital, and/or hand/foot). Participants were randomized to receive either icotrokinra 200 mg QD from Week 0 to Week 156 or placebo from Week 0 to Week 16 followed by a crossover to icotrokinra from Week 16 to Week 156.

- **77242113PSO3004 (PSO3004):** A Phase 3 multicenter, randomized, double-blind, placebo-controlled and deucravacitinib-active-comparator-controlled trial to evaluate the efficacy and safety of icotrokinra for the treatment of adult participants with moderate to severe plaque psoriasis. Participants were randomized to receive either icotrokinra 200 mg QD from Week 0 to Week 156; placebo from Week 0 to Week 16 followed by a crossover to icotrokinra from Week 16 to Week 156; or deucravacitinib from Week 0 to Week 24 followed by a crossover to icotrokinra from Week 24 to Week 156.

SIII.2. Clinical Trial Exposure

Clinical trial exposure to icotrokinra is presented in the following tables by duration of exposure, by dose, by age group and sex, and by race and ethnicity.

Exposure in Randomized, Placebo-Controlled, Blinded Clinical Trials

The tables below present icotrokinra exposure from the following randomized, placebo-controlled, blinded clinical trials:

- PSO2001
- PSO3001
- PSO3002
- PSO3003
- PSO3004

Table SIII.1: JNJ-77242113 Exposure in Randomized, Placebo-Controlled, Blinded Clinical Trials by Duration of Exposure

	Participants, No.	Follow-up, Years
Psoriasis trials ^a		
Participants treated with JNJ-77242113	1,508	
16 weeks ^b	1,132	354.4
Total	1,508	459.9

^a Includes participants treated with JNJ-77242113 in 77242113PSO2001 through Week 16 (with safety follow-up up to Week 20) and 77242113PSO3001, 77242113PSO3002, 77242113PSO3003, and 77242113PSO3004 through Week 16.

^b Includes participants who completed 16 weeks of JNJ-77242113 treatment.

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Table SIII.2: JNJ-77242113 Exposure in Randomized, Placebo-Controlled, Blinded Clinical Trials by Dose

	Participants, No.	Follow-up, Years
Psoriasis trials ^a		
25 mg qd	43	12.9
50 mg qd	43	13.0
25 mg bid	41	12.7
100 mg qd	43	13.2
100 mg bid	42	12.7
200 mg qd	1,296	395.3
Total	1,508	459.9

^a Includes participants treated with JNJ-77242113 in 77242113PSO2001 through Week 16 (with safety follow-up up to Week 20) and 77242113PSO3001, 77242113PSO3002, 77242113PSO3003, and 77242113PSO3004 through Week 16.

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Table SIII.3: JNJ-77242113 Exposure in Randomized, Placebo-Controlled, Blinded Clinical Trials by Age Group and Sex

	Sex			
	Male		Female	
	Participants, No.	Follow-up, Years	Participants, No.	Follow-up, Years
Psoriasis trials ^a				
Adolescents				
12-17 years ^b	22	6.8	25	7.8
Adults				
18-44 years	490	149.4	219	67.5
45-64 years	429	129.8	184	56.3
Elderly				
65-74 years	64	19.8	53	15.9
75-84 years	13	4.0	8	2.4
≥85 years	1	0.3	0	0
Total	1,019	310.1	489	149.8

^a Includes participants treated with JNJ-77242113 in 77242113PSO2001 through Week 16 (with safety follow-up up to Week 20) and 77242113PSO3001, 77242113PSO3002, 77242113PSO3003, and 77242113PSO3004 through Week 16.

^b Adolescent participants enrolled in 77242113PSO3001 and 77242113PSO3003.

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Table SIII.4: JNJ-77242113 Exposure in Randomized, Placebo-Controlled, Blinded Clinical Trials by Race and Ethnicity

	Participants, No.	Follow-up, Years
Psoriasis trials ^a		
Race		
American Indian or Alaska Native	6	1.9
Asian	298	90.4
Black or African American	26	7.9
Native Hawaiian or Other Pacific Islander	8	2.5
White	1,147	350.4
Multiple	3	0.9
Not Reported	14	4.2
Unknown	6	1.9
Ethnicity		
Hispanic or Latino	192	59.2
Not Hispanic or Latino	1,292	393.7
Not Reported	15	4.3
Unknown	9	2.8
Total	1,508	459.9

^a Includes participants treated with JNJ-77242113 in 77242113PSO2001 through Week 16 (with safety follow-up up to Week 20) and 77242113PSO3001, 77242113PSO3002, 77242113PSO3003, and 77242113PSO3004 through Week 16.

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Exposure in All Clinical Trials

The tables below present icotrokinra exposure from all clinical trials:

- PSO2001
- PSO2002
- PSO3001
- PSO3002
- PSO3003
- PSO3004

For Trials PSO3001, PSO3002, PSO3003, and PSO3004, the safety data cut-off date reflects the date through which all safety data were collected, which may be beyond the last efficacy visit: ie, 03 April 2025 in PSO3001 (after the last participant completed the Week 52 visit), 03 April 2025 in PSO3002 (after the last participant completed the Week 44 visit), 19 February 2025 in PSO3003 (after the last participant completed the Week 52 visit), and 06 January 2025 in PSO3004 (after the last participant completed the Week 24 visit).

Table SIII.5: JNJ-77242113 Exposure in All Clinical Trials by Duration of Exposure

	Participants, No.	Follow-up, Years
Psoriasis trials ^a		
Participants treated with JNJ-77242113	2,614	
6 months ^b	2,054	1,662.6
1 year ^c	786	827.8
Total	2,614	1,793.8

^a Includes participants treated with JNJ-77242113 (including participants who crossed over from placebo or switched from deucravacitinib to JNJ-77242113) in 77242113PSO2001 through Week 16 (with safety follow-up up to Week 20), 77242113PSO2002 through Week 36 (with safety follow-up up to Week 40), and 77242113PSO3001, 77242113PSO3002, 77242113PSO3003, and 77242113PSO3004 through the safety data cut-off date.

^b The duration between the first and last JNJ-77242113 administration was at least 26 weeks.

^c The duration between the first and last JNJ-77242113 administration was at least 52 weeks.

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Table SIII.6: JNJ-77242113 Exposure in All Clinical Trials by Dose

	Participants, No.	Follow-up, Years
Psoriasis trials ^a		
25 mg qd	43	37.4
50 mg qd	43	41.6
25 mg bid	41	39.4
100 mg qd	78	66.0
100 mg bid	42	40.8
200 mg qd	2,367	1,568.6
Total	2,614	1,793.8

^a Includes participants treated with JNJ-77242113 (including participants who crossed over from placebo or switched from deucravacitinib to JNJ-77242113) in 77242113PSO2001 through Week 16 (with safety follow-up up to Week 20), 77242113PSO2002 through Week 36 (with safety follow-up up to Week 40), and 77242113PSO3001, 77242113PSO3002, 77242113PSO3003, and 77242113PSO3004 through the safety data cut-off date.

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Table SIII.7: JNJ-77242113 Exposure in All Clinical Trials by Age Group and Sex

	Sex			
	Male		Female	
	Participants, No.	Follow-up, Years	Participants, No.	Follow-up, Years
Psoriasis trials ^a				
Adolescents				
12-17 years ^b	31	27.6	41	36.8
Adults				
18-44 years	835	566.1	372	253.2
45-64 years	728	506.4	349	236.3
Elderly				
65-74 years	134	90.3	88	53.9
75-84 years	18	12.5	15	8.7
≥85 years	2	1.8	1	0.1
Total	1,748	1,204.7	866	589.0

^a Includes participants treated with JNJ-77242113 (including participants who crossed over from placebo or switched from deucravacitinib to JNJ-77242113) in 77242113PSO2001 through Week 16 (with safety follow-up up to Week 20), 77242113PSO2002 through Week 36 (with safety follow-up up to Week 40), and 77242113PSO3001, 77242113PSO3002, 77242113PSO3003, and 77242113PSO3004 through the safety data cut-off date.

^b Adolescent participants enrolled in 77242113PSO3001 and 77242113PSO3003.

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Table SIII.8: JNJ-77242113 Exposure in All Clinical Trials by Race and Ethnicity

	Participants, No.	Follow-up, Years
Psoriasis trials ^a		
Race		
American Indian or Alaska Native	10	8.0
Asian	520	384.6
Black or African American	42	23.3
Native Hawaiian or Other Pacific Islander	11	7.8
White	1,996	1,346.0
Multiple	4	2.1
Not Reported	22	14.6
Unknown	9	7.5
Ethnicity		
Hispanic or Latino	341	218.3
Not Hispanic or Latino	2,242	1,549.7
Not Reported	20	16.5
Unknown	11	9.3
Total	2,614	1,793.8

^a Includes participants treated with JNJ-77242113 (including participants who crossed over from placebo or switched from deucravacitinib to JNJ-77242113) in 77242113PSO2001 through Week 16 (with safety follow-up up to Week 20), 77242113PSO2002 through Week 36 (with safety follow-up up to Week 40), and 77242113PSO3001, 77242113PSO3002, 77242113PSO3003, and 77242113PSO3004 through the safety data cut-off date.

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PART II: SAFETY SPECIFICATION

Module SIV: Populations Not Studied in Clinical Trials

SIV.1. Important Exclusion Criteria in Pivotal Clinical Trials Across the Development Program

Criterion 1	Has a current diagnosis or signs or symptoms of severe, progressive, or uncontrolled renal, liver, cardiac, vascular, pulmonary, gastrointestinal, endocrine, neurologic, hematologic, rheumatologic, psychiatric, or metabolic disturbances.
Reason for being an exclusion criterion	Inclusion of such patients could confound the safety evaluation of icotrokinra.
Included as missing information?	No
Rationale if not included as missing information	This exclusion criterion was implemented for the purpose of the clinical trials and not for a specific safety concern.
Criterion 2	Has known allergies, hypersensitivity, or intolerance to icotrokinra or to any of the excipients of the formulation.
Reason for being an exclusion criterion	These patients are likely to react upon re-exposure and were excluded from icotrokinra clinical trials to avoid potentially severe hypersensitivity reactions.
Included as missing information?	No
Rationale if not included as missing information	Icotrokinra is contraindicated in patients with a known hypersensitivity to the active substance or to any of the excipients in the formulation (SmPC Section 4.3).
Criterion 3	Received or is expected to receive a live virus or bacterial vaccination within 4 weeks (or longer if required per vaccine package insert) prior to the first administration of study intervention through the end of the study.
	Has had or is expected to have a Bacille Calmette-Guérin vaccination within 1 year prior to the first administration of study intervention through the end of the study.
Reason for being an exclusion criterion	This criterion was included as a precautionary measure, as it is unknown if inhibition of the IL-23 pathway may increase the risk of vaccine-derived infection.
Included as missing information?	No
Rationale if not included as missing information	Administration of live vaccines is not recommended during treatment with icotrokinra and within 3 days after discontinuation of icotrokinra (SmPC Sections 4.4 and 4.5).

Criterion 4	Currently has a malignancy or has a history of malignancy within 5 years before screening (except nonmelanoma skin cancer or cervical carcinoma in situ that has been adequately treated with no evidence of recurrence for at least 12 weeks before the first study intervention administration). Has a history of lymphoproliferative disease, including lymphoma; a history of monoclonal gammopathy of undetermined significance; or signs and symptoms suggestive of possible lymphoproliferative disease, such as splenomegaly or significant lymphadenopathy.
Reason for being an exclusion criterion	Immunomodulators may theoretically promote the risk of malignancy. Additionally, inclusion of such patients could confound the safety evaluation of icotrokinra.
Included as missing information?	No
Rationale if not included as missing information	Nonclinical and clinical data do not suggest an association between icotrokinra and malignancy, nor does the mode of action of icotrokinra.
Criterion 5	Women who are pregnant or breastfeeding or intending to become pregnant during the study or within 4 weeks after the last dose of study intervention.
Reason for being an exclusion criterion	Pregnant and breastfeeding women are generally excluded from clinical trials.
Included as missing information?	Pregnancy: Yes Breastfeeding: No
Rationale if not included as missing information	Breastfeeding: Nonclinical and clinical pharmacology data do not suggest any risks of clinical significance in infants exposed to icotrokinra via breast milk.
Criterion 6	Has a history of chronic or recurrent infectious disease. Has a known or suspected immunodeficiency. Has a serious infection or has been hospitalized or received intravenous antibiotics for an infection during the 8 weeks before screening.
Reason for being an exclusion criterion	Immunomodulators may theoretically promote the risk of infection. Additionally, inclusion of such patients could confound the safety evaluation of icotrokinra.
Included as missing information?	No
Rationale if not included as missing information	Nonclinical and clinical data do not suggest an association between icotrokinra and infections. Icotrokinra is contraindicated in patients with clinically important active infections (eg, active tuberculosis) (SmPC Section 4.3). Treatment should not be initiated in patients with any clinically important active infection until the infection resolves or is adequately treated (SmPC Section 4.4).

Criterion 7	Has an active tuberculosis infection.
Reason for being an exclusion criterion	Immunomodulators may theoretically promote the risk of infection. Additionally, inclusion of such patients could confound the safety evaluation of icotrokinra.
Included as missing information?	No
Rationale if not included as missing information	Nonclinical and clinical data do not suggest an association between icotrokinra and infections. Icotrokinra is contraindicated in patients with clinically important active infections (eg, active tuberculosis) (SmPC Section 4.3). Treatment should not be initiated in patients with any clinically important active infection until the infection resolves or is adequately treated (SmPC Section 4.4).

SIV.2. Limitations to Detecting Adverse Reactions in the Clinical Development Program

The clinical development program is unlikely to detect certain types of adverse reactions, such as rare adverse reactions, adverse reactions with a long latency, and adverse reactions caused by prolonged or cumulative exposure.

SIV.3. Limitations With Respect to Populations Typically Under-represented in Clinical Development Programs

Table Module SIV.3: Exposure of Special Populations Included or Not in the Clinical Development Program

Type of Special Population	Exposure
Pregnant women	Although pregnant women were excluded from plaque psoriasis clinical trials per protocol, exposure to icotrokinra during pregnancy occurred in the psoriasis clinical development program. As of 01 May 2025, 5 reports of incidental pregnancy were identified in female participants exposed to icotrokinra, and 10 reports of pregnancy were identified in partners of male participants exposed to icotrokinra.
Breastfeeding women	Not included in the plaque psoriasis clinical development program.
Population of relevant different racial or ethnic origin	Of the 2,614 icotrokinra-treated participants in the plaque psoriasis clinical trials, 1,996 (76%) were white, 520 (20%) were Asian, 42 (2%) were black or African American, and 56 (2%) were of other, mixed, or unknown racial background. Of the 2,614 icotrokinra-treated participants in the plaque psoriasis clinical trials, 2,242 (86%) were non-Hispanic or non-Latino, 341 (13%) were Hispanic or Latino, and 31 (1%) were of unknown ethnicity.
Subpopulations carrying relevant genetic polymorphisms	A genetic analysis of plaque psoriasis clinical data identified no relevant genetic polymorphisms in participants exposed to icotrokinra or variants significantly associated with clinical

	efficacy.
Elderly	Of the 2,614 icotrokinra-treated participants in the plaque psoriasis clinical trials, 258 (10%) were ≥ 65 years of age, 36 (1%) were ≥ 75 years of age, and 3 (0.1%) were ≥ 85 years of age.
Adolescents	Of the 2,614 icotrokinra-treated participants in the plaque psoriasis clinical trials, 72 (3%) were 12 to 17 years of age.
Patients with relevant comorbidities	
Patients with hepatic impairment Patients with cardiovascular impairment Immunocompromised patients Patients with a disease severity different from inclusion criteria in clinical trials	Although participants with these comorbidities may have been included in the clinical development program at the discretion of the investigator, no exposure data are available.
Patients with renal impairment	Patients with a current diagnosis or signs or symptoms of severe, progressive, or uncontrolled renal disturbances were not included in the Phase 3 plaque psoriasis clinical trials. Eight participants with severe renal impairment ($\text{eGFR} \geq 15$ to < 30 mL/min) and 5 participants with moderate renal impairment ($\text{eGFR} \geq 30$ to < 60 mL/min) were included in the Phase 1 trial PSO1007.

PART II: SAFETY SPECIFICATION**Module SV: Postauthorization Experience****SV.1. Postauthorization Exposure****SV.1.1. Method Used to Calculate Exposure**

Not applicable.

SV.1.2. Exposure

No postmarketing exposure data are available, as ICOTYDE is not currently marketed.

PART II: SAFETY SPECIFICATION

Module SVI: Additional EU Requirements for the Safety Specification

Potential for Misuse for Illegal Purposes

The pharmacokinetic and pharmacodynamic properties of icotrokinra are not characteristic of drugs with abuse potential. The potential for the misuse of icotrokinra for illegal purposes is unlikely.

PART II: SAFETY SPECIFICATION

Module SVII: Identified and Potential Risks and Missing Information

SVII.1. Identification of Safety Concerns in the Initial RMP Submission

SVII.1.1. Risks Not Considered Important for Inclusion in the List of Safety Concerns

Known risks that require no further characterization and are followed up via routine pharmacovigilance:

- Diverticulitis
- Fungal infections

SVII.1.2. Important Risks and Missing Information for Inclusion in the List of Safety Concerns

Safety Concerns	Risk-Benefit Impact
Missing information	
Use during pregnancy	Pregnant women were excluded from icotrokinra clinical trials. Nonclinical studies do not suggest harmful effects with respect to pregnancy, embryo-fetal development, or pre- or post-natal development. However, it is unknown whether icotrokinra crosses the placenta or whether exposure to icotrokinra during pregnancy poses risks to pregnant women or their offspring.

SVII.2. New, Reclassified, and Removed Safety Concerns with Submission of an Updated RMP

Not applicable.

SVII.3. Details of Important Identified Risks, Important Potential Risks, and Missing Information

Important Identified Risks

None

Important Potential Risks

None

Missing Information

Use during pregnancy

SVII.3.1. Presentation of Important Identified Risks and Important Potential Risks

Not applicable.

SVII.3.2. Presentation of the Missing Information**Missing Information: Use During Pregnancy**Evidence Source

Nonclinical studies demonstrated no effects on embryo-fetal or pre- or post-natal development following oral administration of icotrokinra. However, because pregnant women were excluded from icotrokinra clinical trials, it is unknown whether icotrokinra crosses the placenta or whether exposure to icotrokinra during pregnancy poses risks to pregnant women or their offspring.

Population in need of further characterization

Pregnant women who are treated with icotrokinra.

PART II: SAFETY SPECIFICATION**Module SVIII: Summary of the Safety Concerns****Table Module SVIII: Summary of Safety Concerns**

Important Identified Risks	None
Important Potential Risks	None
Missing Information	Use during pregnancy

PART III: PHARMACOVIGILANCE PLAN **(Including Postauthorization Safety Studies)**

III.1. Routine Pharmacovigilance Activities Beyond Adverse Reaction Reporting and Signal Detection

Specific Adverse Reaction Follow-up Questionnaires

Safety Concern	Purpose/Description
Not applicable	

Other Forms of Routine Pharmacovigilance Activities

Activity	Objective(s)	Milestones
Not applicable		

III.2. Additional Pharmacovigilance Activities

Study name and title	A Retrospective Cohort Study Using Administrative Health Insurance Claims Databases to Assess Adverse Pregnancy, Fetal, and Infant Outcomes in Women Who Were Exposed to Icotrokinra for an Authorized Indication During Pregnancy
Rationale and study objectives	To monitor pregnancy outcomes in women exposed to icotrokinra for an authorized indication during pregnancy and linked infant outcomes in infants up to 1 year of age.
Safety concerns addressed	Use during pregnancy
Study design	Observational, retrospective cohort study using 2 administrative health insurance claims databases in the United States.
Study population	Pregnant women aged ≥ 18 to ≤ 49 years at pregnancy start who have been treated with icotrokinra for an authorized indication or comparator treatment during pregnancy and have a known pregnancy outcome.
Milestones	Protocol submission: 30 Jun 2027 Start of data collection: 31 Dec 2030 Interim reports: 31 Dec 2031, 31 Dec 2034 End of data collection: 31 Mar 2037 Final study report submission: 31 Mar 2038

III.3. Summary Table of Additional Pharmacovigilance Activities

Table Part III.3: Ongoing and Planned Additional Pharmacovigilance Activities

Study and Status	Summary of Objectives	Safety Concern(s) Addressed	Milestones	Due Dates
Category 1: Imposed mandatory additional pharmacovigilance activities which are conditions of the marketing authorization				
Not applicable				
Category 2: Imposed mandatory additional pharmacovigilance activities which are specific obligations in the context of a conditional marketing authorization or a marketing authorization under exceptional circumstances				
Not applicable				
Category 3: Required additional pharmacovigilance activities				
A Retrospective Cohort Study Using Administrative Health Insurance Claims Databases to Assess Adverse Pregnancy, Fetal, and Infant Outcomes in Women Who Were Exposed to Icotrokinra for an Authorized Indication During Pregnancy Planned	To monitor pregnancy outcomes in women exposed to icotrokinra for an authorized indication during pregnancy and linked infant outcomes in infants up to 1 year of age	Use during pregnancy	Protocol submission	30 Jun 2027
			Start of data collection	31 Dec 2030
			Interim reports	31 Dec 2031 31 Dec 2034
			End of data collection	31 Mar 2037
			Final study report submission	31 Mar 2038

PART IV: PLANS FOR POSTAUTHORIZATION EFFICACY STUDIES**Table Part IV: Planned and Ongoing Postauthorization Efficacy Studies That Are Conditions of the Marketing Authorization or Specific Obligations**

Study and Status	Summary of Objectives	Efficacy Uncertainties Addressed	Milestones	Due Dates
Efficacy studies which are conditions of the marketing authorization				
Not applicable				
Efficacy studies which are specific obligations in the context of a conditional marketing authorization or a marketing authorization under exceptional circumstances				
Not applicable				

PART V: RISK MINIMIZATION MEASURES

(Including Evaluation of the Effectiveness of Risk Minimization Activities)

Risk Minimization Plan

V.1. Routine Risk Minimization Measures

Table Part V.1: Description of Routine Risk Minimization Measures by Safety Concern

Use during pregnancy
Routine risk communication - SmPC Section 4.6 - PL Section 2 Routine risk minimization activities recommending specific clinical measures to address the risk - A recommendation to avoid the use of ICOTYDE during pregnancy is included in SmPC Section 4.6. - A recommendation to avoid administration of live vaccines to newborns potentially exposed to icotrokinra during pregnancy within the first 3 days after birth is included in SmPC Section 4.6 and PL Section 2. - Advice for patients who are pregnant, think that they may be pregnant, or are planning to have a baby is included in PL Section 2. Other routine risk minimization activities beyond the Product Information None

V.2. Additional Risk Minimization Measures

Not applicable. Routine risk minimization activities as described in Part V.1 are sufficient to manage the safety concerns of icotrokinra.

V.2.1. Removal of Additional Risk Minimization Activities

Not applicable.

V.3. Summary of Risk Minimization Measures

Table Part V.3: Summary of Risk Minimization Activities and Pharmacovigilance Activities by Safety Concern

Safety Concern	Risk Minimization Measures	Pharmacovigilance Activities
Use during pregnancy	Routine risk minimization activities - SmPC Section 4.6 - PL Section 2 Additional risk minimization activities None	Routine pharmacovigilance activities beyond adverse reactions reporting and signal detection None Additional pharmacovigilance activities A Retrospective Cohort Study Using Administrative Health Insurance Claims Databases to Assess Adverse Pregnancy, Fetal, and Infant Outcomes in Women Who Were Exposed to Icotrokinra for an Authorized Indication During Pregnancy Final study report due date: 31 Mar 2038

PART VI: SUMMARY OF THE RISK MANAGEMENT PLAN

Summary of Risk Management Plan for ICOTYDE (Icotrokinra)

This is a summary of the risk management plan (RMP) for ICOTYDE. The RMP details important risks of ICOTYDE, how these risks can be minimized, and how more information will be obtained about ICOTYDE's risks and uncertainties (missing information).

ICOTYDE's Summary of Product Characteristics (SmPC) and its Package Leaflet give essential information to healthcare professionals and patients on how ICOTYDE should be used.

This summary of the RMP for ICOTYDE should be read in the context of all this information including the assessment report of the evaluation and its plain-language summary, all which is part of the European Public Assessment Report (EPAR).

Important new concerns or changes to the current ones will be included in updates of ICOTYDE's RMP.

I. The Medicine and What it is Used For

ICOTYDE is authorized for the treatment of moderate to severe plaque psoriasis in adults, and adolescents 12 years of age and older and weighing at least 40 kg, who are candidates for systemic therapy (see SmPC for the full indications). It contains icotrokinra as the active substance and it is given orally.

Further information about the evaluation of ICOTYDE's benefits can be found in ICOTYDE's EPAR, including in its plain-language summary, available on the European Medicines Agency (EMA) website under the medicine's webpage: [link to the EPAR summary landing page](#).

II. Risks Associated with the Medicine and Activities to Minimize or Further Characterize the Risks

Important risks of ICOTYDE, together with measures to minimize such risks and the studies for learning more about ICOTYDE's risks, are outlined below.

Measures to minimize the risks identified for medicinal products can be:

- Specific information, such as warnings, precautions, and advice on correct use, in the Package Leaflet and SmPC addressed to patients and healthcare professionals.
- Important advice on the medicine's packaging.
- The authorized pack size — the amount of medicine in a pack is chosen so to ensure that the medicine is used correctly.
- The medicine's legal status — the way a medicine is supplied to the patient (eg, with or without prescription) can help to minimize its risks.

Together, these measures constitute *routine risk minimization measures*.

In addition to these measures, information about adverse reactions is collected continuously and regularly analyzed, including Periodic Safety Update Report (PSUR) assessment, so that immediate action can be taken as necessary. These measures constitute *routine pharmacovigilance activities*.

If important information that may affect the safe use of ICOTYDE is not yet available, it is listed under ‘missing information’ below.

II.A. List of Important Risks and Missing Information

Important risks of ICOTYDE are risks that need special risk management activities to further investigate or minimize the risk so that the medicinal product can be safely taken. Important risks can be regarded as identified or potential. Identified risks are concerns for which there is sufficient proof of a link with the use of ICOTYDE. Potential risks are concerns for which an association with the use of this medicine is possible based on available data, but this association has not been established yet and needs further evaluation. Missing information refers to information on the safety of the medicinal product that is currently missing and needs to be collected (eg, on the long-term use of the medicine).

List of Important Risks and Missing Information	
Important identified risks	None
Important potential risks	None
Missing information	Use during pregnancy

II.B. Summary of Important Risks and Missing Information

Missing information: Use during pregnancy	
Risk minimization measures	Routine risk minimization measures - SmPC Section 4.6 - PL Section 2 Additional risk minimization measures None
Additional pharmacovigilance activities	A Retrospective Cohort Study Using Administrative Health Insurance Claims Databases to Assess Adverse Pregnancy, Fetal, and Infant Outcomes in Women Who Were Exposed to Icotrokinra for an Authorized Indication During Pregnancy See section II.C of this summary for an overview of the postauthorization development plan.

II.C. Postauthorization Development Plan

II.C.1. Studies That are Conditions of the Marketing Authorization

No studies are conditions of the marketing authorization or specific obligations of ICOTYDE.

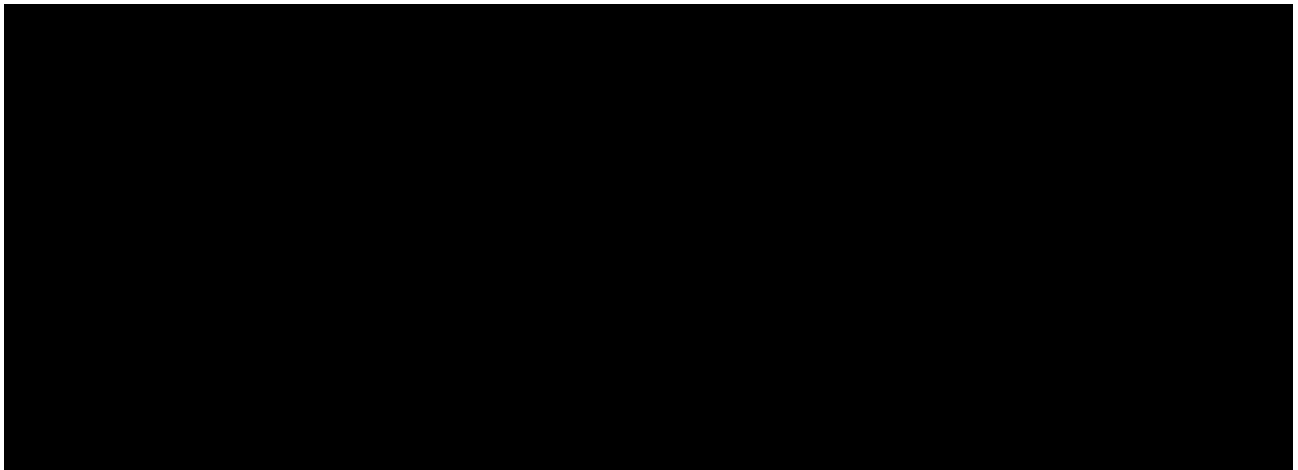
II.C.2. Other Studies in Postauthorization Development Plan

1. A Retrospective Cohort Study Using Administrative Health Insurance Claims Databases to Assess Adverse Pregnancy, Fetal, and Infant Outcomes in Women Who Were Exposed to Icotrokinra for an Authorized Indication During Pregnancy

Purpose of the study: To monitor pregnancy outcomes in women exposed to icotrokinra for an authorized indication during pregnancy and linked infant outcomes in infants up to 1 year of age.

PART VII: ANNEXES

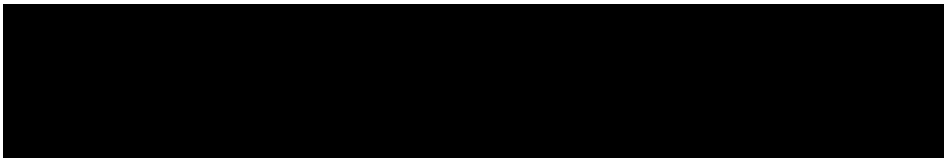
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Annex 4 Specific Adverse Reaction Follow-up Questionnaires



Annex 6 Details of Additional Risk Minimization Activities



Annex 4: Specific Adverse Reaction Follow-up Questionnaires

Not applicable

Annex 6: Details of Additional Risk Minimization Activities

Key Messages of Additional Risk Minimization Activities

Not applicable