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Facility/Practice staff

Pharmacy Formulary Updates Effective April 1, 2025

The MVP Health Care® (MVP) Pharmacy and Therapeutics (P&T) Committee has determined that the following drugs, which have been recently approved by the FDA, will require prior authorization for at least the first six months following the date they are available on the market. The most current versions of our Formularies and Prior Authorization forms are available at mvphealthcare.com.

| CHEMICAL ENTITIES | | | | | |
|--|---|-----------------------------|--------------------------|-------------------------------------|-----------------------------|
| DRUG NAME | INDICATION | COMMERCIAL | MEDICAID | MEDICARE | EXCHANGE |
| Ebglyss™ (lebrikizumab-lbkz) | The treatment of moderate-to-severe atopic dermatitis in patients ages 12 years and older and weighing at least 40 kg whose disease is not adequately controlled with topical prescription therapies, or when those therapies are not advisable | Prior Authorization, Tier 3 | NYRX Medicaid Transition | Part D, Non-Formulary | Prior Authorization, Tier 3 |
| Miplyffa™ (arimoclomol) | The treatment of neurological manifestations due to Niemann-Pick disease type C in patients ages 2 years and older, in combination with miglustat | | | | |
| | Prior Authorization, Tier 3 | NYRX Medicaid Transition | Part D, Non-Formulary | Prior Authorization, Tier 3 | |
| Aqneursa™ (levacetylleucine) | The treatment of neurological manifestations of Niemann-Pick type C disease in adults and pediatrics weighing at least 15 kg; stand-alone therapy | Prior Authorization, Tier 3 | NYRX Medicaid Transition | Part D, Non-Formulary | Prior Authorization, Tier 3 |
| Cobenfy™ (xanomeline and trospium chloride) | The treatment of schizophrenia in adults | Prior Authorization, Tier 3 | NYRX Medicaid Transition | Part D, Prior Authorization, Tier 5 | Prior Authorization, Tier 3 |

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|---|--|--|------------------------------|--|--|
| Vyalev™ (foscarbidopa/foslevolopa) | The treatment of motor fluctuation in adults with advanced Parkinson's disease | Prior Authorization, Tier 3 | NYRX Medicaid Transition | Part D, Non-Formulary | Prior Authorization, Tier 3 |
| Vyloy® (zolbetuximab-clzb) | The first-line treatment of HER2-negative, locally advanced, unresectable or metastatic gastric or gastroesophageal junction adenocarcinoma, that is claudin 18.2-positive, in combination with chemotherapy | Prior Authorization, Medical | Prior Authorization, Medical | Prior Authorization, Medical (Part B) Part D, Non-Formulary | Prior Authorization, Medical |
| Itovebi™ (inavolisib) | Indicated in combination with palbociclib and fulvestrant for the treatment of adults with endo-crine-resistant, PIK3CA-mutated, hormone recep-tor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-neg-ative, locally advanced or metastatic breast cancer, as detected by an FDA-approved test, following recurrence on or after completing adjuvant endo-crine therapy. | Prior Authorization, Tier 3 and oral chemo copay | NYRX Medicaid Transition | Part D, Prior Authorization, Tier 5 | Prior Authorization, Tier 3 and oral chemo copay |
| Hympavzi™ (marstacimab-hncq) | Routine prophylaxis to prevent or reduce the frequency of bleeding episodes in patients ages 12 years and older with hemophilia A without factor VIII inhibitors, or hemophilia B without factor IX inhibitors | Prior Authorization, Tier 3 | NYRX Medicaid Transition | Part D, Non-Formulary | Prior Authorization, Tier 3 |

NEW CHEMICAL ENTITIES

| DRUG NAME | INDICATION | COMMERCIAL | MEDICAID | MEDICARE | EXCHANGE |
|------------------------------------|--|--|------------------------------|--|--|
| Revuforj® (revumenib) | A menin inhibitor indicated for the treatment of relapsed or refractory acute leukemia with a lysine methyltransferase 2A gene (KMT2A) translocation in adult and pediatric patients 1 year and older. | Prior Authorization, Tier 3 and oral chemo copay | NYRX Medicaid Transition | Part D, Non-Formulary | Prior Authorization, Tier 3 and oral chemo copay |
| Ziibera® (zanidatamab-hrii) | Indicated for the treatment of adults with previously treated, unresectable or metastatic HER2-positive (IHC 3+) biliary tract cancer (BTC), as detected by an FDA-approved test. | Prior Authorization, Medical | Prior Authorization, Medical | Prior Authorization, Medical (Part B) Part D, Non-Formulary | Prior Authorization, Medical |
| Attruby™ (acoramidis) | Treatment of cardiomyopathy of wild-type or variant transthyretin-mediated amyloidosis (ATTR-CM) in adults to reduce cardiovascular death and cardiovascular-related hospitalization. | Prior Authorization, Tier 3 | NYRX Medicaid Transition | Part D, Non-Formulary | Prior Authorization, Tier 3 |

NEW CHEMICAL ENTITIES

| DRUG NAME | INDICATION | COMMERCIAL | MEDICAID | MEDICARE | EXCHANGE |
|---|---|--|--|--|--|
| Femlyv™ (norethindrone acetate/ethinyl estradiol) | The prevention of pregnancy in females of reproductive potential | Prior Authorization, Tier 3 | NYRX Medicaid Transition | Part D, Non-Formulary | Prior Authorization, Tier 3 |
| Tecentriq Hybreza™ (atezolizumab and hyaluronidase-tqjs) | The treatment of non-small cell lung cancer, small cell lung cancer, hepatocellular carcinoma, and melanoma in adults, and the treatment of alveolar soft part sarcoma in patients aged 2 years and older | Prior Authorization per Cancer Guidance Program, Medical | Prior Authorization per Cancer Guidance Program, Medical | Prior Authorization, Medical (Part B) Part D, Non-Formulary | Prior Authorization per Cancer Guidance Program, Medical |

NEW CHEMICAL ENTITIES

| DRUG NAME | INDICATION | COMMERCIAL | MEDICAID | MEDICARE | EXCHANGE |
|---|--|------------------------------|------------------------------|--|------------------------------|
| Pavblu™ (afibercept-ayyh) | Treatment of neovascular (wet) age-related macular degeneration (wAMD), macular edema following retinal vein occlusion (MEFRVO), diabetic macular edema (DME), and diabetic retinopathy (DR). | Medical | Medical | Medical (Part B) Part D, Non-Formulary | Medical |
| Aurlumyn™ (iloprost) | Treatment of severe frostbite in adults to reduce the risk of digit amputations. Effectiveness was established in young, healthy adults who suffered frostbite at high altitudes. | Prior Authorization, Medical | Prior Authorization, Medical | Prior Authorization, Medical (Part B) Part D, Non-Formulary | Prior Authorization, Medical |
| Azmiro™ (testosterone cypionate) | Indicated for testosterone replacement therapy in males for conditions associated with a deficiency or absence of endogenous testosterone. | Prior Authorization, Medical | Prior Authorization, Medical | Prior Authorization, Medical (Part B) Part D, Non-Formulary | Prior Authorization, Medical |
| Opipza™ (aripiprazole) | The treatment of schizophrenia in patients ages 13 years and older, the adjunctive treatment of major depressive disorder in adults, the treatment of irritability associated with autistic disorder in patients ages 6 years and older, and the treatment of Tourette's disorder in patients ages 6 years and older | Prior Authorization, Tier 3 | NYRX Medicaid Transition | Part D, Non-Formulary | Prior Authorization, Tier 3 |

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| Danziten™ (nilotinib) | Indicated to treat: - Adult patients with newly diagnosed Philadelphia chrom-osome positive chronic myeloid leukemia (Ph+ CML) in chronic phase. - Adult patients with chronic phase (CP) and accelerated phase (AP) Ph+ CML resistant to or intolerant to prior therapy that included imatinib. | Prior Authorization, Tier 3 and oral chemo copay | NYRX Medicaid Transition | Part D, Non-Formulary | Prior Authorization, Tier 3 and oral chemo copay |
| Nypozi™ (filgrastim-txid) | Treatment of neutropenia, mobilization of cells for collection by leukapheresis, and increase survival following myelosuppressive doses of radiation | Prior Authorization, Tier 3 | NYRX Medicaid Transition | Part D, Non-Formulary | Prior Authorization, Tier 3 |
| Hercessi™ (trastuzumab-strf) | The treatment of HER2-overexpressing breast cancer, and the treatment of HER2-overexpressing gastric or gastroesophageal junction adenocarcinoma. | Prior Authorization per Cancer Guidance Program, Medical | Prior Authorization per Cancer Guidance Program, Medical | Prior Authorization per Cancer Guidance Program, Medical (Part B) Part D, Non-Formulary | Prior Authorization per Cancer Guidance Program, Medical |

| NEW GENERICS (all brands will be non-formulary, Tier 3) | | | | |
|--|-----------------------------|-------------------|--------------------------|-----------------|
| BRAND NAME | GENERIC NAME | COMMERCIAL | MEDICAID | EXCHANGE |
| Sandostatin LAR Kit | Octreotide IM inj | Medical | Medical | Medical |
| Solu-Cortef | Hydrocortisone succinate PF | Tier 1 | NYRX Medicaid Transition | Tier 2 |

