

MVPFASTFAX

Important News for **Providers**

This communication should be viewed by:
Facility/Practice staff

Formulary Updates Effective December 1, 2026

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.

NEW CHEMICAL ENTITIES						
DRUG NAME	INDICATION	COMMERCIAL	CHP	MEDICAID	MEDICARE	EXCHANGE
Yartemlea® (narsoplimab-wuug)	Indicated for the treatment of adult and pediatric patients 2 years of age and older with hematopoietic stem cell transplant-associated thrombotic microangiopathy (TATMA)	Prior Authorization, Medical	Prior Authorization, Medical	Prior Authorization, Medical	Prior Authorization, Medical (Part B) Part D, Non-Formulary	Prior Authorization, Medical
Xocova® (ensitrelvir)	Indicated for post-exposure prophylaxis of COVID-19 in adults and adolescents 12 years of age and older following contact with an individual who has COVID-19	Prior Authorization, Tier 3	Prior Authorization, Non-Formulary	NY RX Medicaid Transition	Part D, Non-Formulary	Prior Authorization, Tier 3
Lynavoy® (linerixibat)	Indicated for the treatment of cholestatic pruritus associated with primary biliary cholangitis (PBC) in adult patients	Prior Authorization, Tier 3	Prior Authorization, Non-Formulary	NY RX Medicaid Transition	Part D, Non-Formulary	Prior Authorization, Tier 3
Veppanu™ (vepdegestrant)	Indicated for the treatment of adults with estrogen receptor (ER)-positive, human epiderma growth factor receptor 2 (HER2 negative, estrogen receptor-1 (ESR1)-mutated advanced or metastatic breast cancer, as detected by an FDA-authorized test, with disease progression following at least one line of endocrine therapy	Prior Authorization, Tier 3	Prior Authorization, Non-Formulary	NY RX Medicaid Transition	Part D, Prior Authorization, Quantity Limitation, Tier 5	Prior Authorization, Tier 3
Lumvoa® (veligrotug-vvze)	Indicated for the treatment of thyroid eye disease (TED) regardless of thyroid eye disease activity or duration	Prior Authorization, Medical	Prior Authorization, Medical	Prior Authorization, Medical	Prior Authorization, Medical (Part B) Part D, Non-Formulary	Prior Authorization, Medical
Awikli® (insulin icodec)	Indicated for the treatment of type 2 diabetes mellitus as an adjunct to diet and exercise	Prior Authorization, Tier 3	Prior Authorization, Non-Formulary	NY RX Medicaid Transition	Part D, Non-Formulary	Prior Authorization, Tier 3
Lipfendra® (enicitide)	Indicated for the treatment of hypercholesterolemia, including heterozygous familial hypercholesterolemia adjunct to diet and exercise	Prior Authorization, Tier 3	Prior Authorization, Non-Formulary	NY RX Medicaid Transition	Part D, Non-Formulary	Prior Authorization, Tier 3

Jideytr [™] (zidesamtinib)	Indicated for the treatment of adult patients with locally advanced or metastatic ROS1- positive non-small cell lung cancer (NSCLC) who received a prior ROS1 kinase inhibitor	Prior Authorization, Tier 3	Prior Authorization, Non-Formulary	NY RX Medicaid Transition	Part D, Prior Authorization, Quantity Limitation, Tier 5	Prior Authorization, Tier 3
Revtorpyk [™] (gedatolisib)	In combination with fulvestrant, with or without palbociclib, for the treatment of adult patients with hormone receptor (HR)- positive, human epidermal growth factor receptor 2 (HER2)- negative locally advanced or metastatic breast cancer without a PIK3CA mutation detected following progression on or after treatment with at least one line of endocrine therapy in the metastatic setting.	Prior Authorization, Medical	Prior Authorization, Medical	Prior Authorization, Medical	Prior Authorization per Cancer Guidance Program, Medical (Part B) Part D, Non-Formulary	Prior Authorization, Medical

NEW COMBINATIONS/FORMULATIONS

DRUG NAME	INDICATION	COMMERCIAL	CHP	MEDICAID	MEDICARE	EXCHANGE
Nufymco [®] (ranibizumab-leyk)	Indicated for the treatment of Neovascular (Wet) Age-Related Macular Degeneration, macular edema following retinal vein occlusion, diabetic macular edema, diabetic Retinopathy, Myopic Choroidal Neovascularization	Prior Authorization, Medical	Prior Authorization, Medical	Prior Authorization, Medical	Prior Authorization, Medical (Part B) Part D, Non-Formulary	Prior Authorization, Medical
Trutakna [™] (atacept-vymj)	Indicated to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk for disease progression	Prior Authorization, Tier 3	Prior Authorization, Tier 3	NY RX Medicaid Transition	Part D, Non-Formulary	Prior Authorization, Tier 3
Cavhanza [™] (nilotinib)	Indicated for the treatment of adults with newly diagnosed Philadelphia chromosome- positive (Ph+) chronic myelogenous leukemia (CML) in chronic phase (CP) and CP and accelerated phase (AP) Ph+ CML resistant to or intolerant to prior therapy that included imatinib.	Prior Authorization, Tier 3	Prior Authorization, Tier 3	NY RX Medicaid Transition	Part D, Prior Authorization, Quantity Limitation, Tier 5	Prior Authorization, Tier 3
Tapentadol solution (tapentadol)	Indicated for the management of acute pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.	Prior Authorization, Tier 3	Prior Authorization, Tier 3	NY RX Medicaid Transition	Part D, Non-Formulary	Prior Authorization, Tier 3

NEW BIOSIMILARS

DRUG NAME	INDICATION	COMMERCIAL	CHP	MEDICAID	MEDICARE	EXCHANGE
Yesafili [™] (aflibercept)	Indicated for the treatment of neovascular (wet) age-related macular degeneration (wAMD), macular edema following retinal vein occlusion (MEFVO), diabetic macular edema (DME), and diabetic retinopathy (DR)	Prior Authorization, Medical	Prior Authorization, Medical	Prior Authorization, Medical	Prior Authorization, Medical (Part B) Part D, Non-Formulary	Prior Authorization, Medical
Omyclo [®] (omalizumab)	Indicated for moderate to severe persistent asthma in adults and pediatric patients 6 years of age and older (inadequately controlled with inhaled corticosteroids), chronic rhinosinusitis with nasal polyps (CRSwNP) in adult patients 18 years of age and older with inadequate response to nasal corticosteroids, as	Add Tier 2 with Prior Authorization per Xolair policy	Add Tier 2 with Prior Authorization per Xolair policy	NYRX Medicaid Transition	Part D, Non-Formulary	Add Tier 2 with Prior Authorization per Xolair policy

	add-on maintenance treatment, IgE-mediated food allergy in adult and pediatric patients aged 1 year and older for the reduction of allergic reactions (Type I) in conjunction with food allergen avoidance, and Chronic spontaneous urticaria (CSU) in adults and adolescents 12 years of age and older who remain symptomatic despite H1 antihistamine treatment. First interchangeable biosimilar to Xolair (omalizumab)					
NEW CELL/GENE THERAPY						
DRUG NAME	INDICATION	COMMERCIAL	CHP	MEDICAID	MEDICARE	EXCHANGE
Tregzi™ (Orca-T) [allogeneic regulatory T cell immunotherapy with HSPC and T cells-vldq]	For use in matched donor hematopoietic stem cell transplantation with myeloablative preparative regimen, for hematopoietic and immunologic reconstitution and to improve chronic graft-versus-host disease (cGVHD)-free survival, in the treatment of adults with hematological malignancies	Prior Authorization, Medical	Prior Authorization, Medical	Prior Authorization, Medical	Prior Authorization, Medical (Part B) Part D, Non-Formulary	Prior Authorization, Medical
NEW GENERICS <i>(all brands will be non-formulary, Tier 3)</i>						
BRAND NAME	GENERIC NAME	COMMERCIAL	CHP	MEDICAID	EXCHANGE	
Bosulif	Bosutinib tablets	Tier 1 and oral chemo copay	Formulary	NYRX Medicaid Transition	Tier 2 and oral chemo copay	
Myrbetriq suspension	Mirabegron ER granules	Tier 1- refer to 2027 Formulary Changes for brand	Formulary	NYRX Medicaid Transition	Tier 2- refer to 2027 Formulary Changes for brand	
Pentasa	Mesalamine ER capsules	Tier 1- refer to 2027 Formulary Changes for brand	Formulary	NYRX Medicaid Transition	Tier 2- refer to 2027 Formulary Changes for brand	
Rhofade cream 1%	Oxymetazoline cream 1%	Tier 1- refer to 2027 Formulary Changes for brand	Formulary	NYRX Medicaid Transition	Tier 2- refer to 2027 Formulary Changes for brand	
Janumet XR	Sitagliptan- Metformin XR	Tier 1- refer to 2027 Formulary Changes for brand	Formulary	NYRX Medicaid Transition	Tier 2- refer to 2027 Formulary Changes for brand	

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