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To: MaineCare Providers
From: Dan Mickool, R.Ph., M.S., Ed D, Associate Director of Pharmacy
Date: January 9, 2026
Re: PDL Update – December 9, 2025

Effective Date: 1/1/2026	
BIN: 005526	PCN: MEPOP
BIN: 005526	PCN: MEPARTD

MaineCare PDL Updates effective January 1, 2026

The following medication has recently been added to the MaineCare PDL as ***preferred*** and will not require prior authorization:

- Pirfenidone
- Tyenne

The following ***preferred*** medication has revised criteria:

- Brinsupri: Clinical PA is required to establish diagnosis and medical necessity. Imaging confirming bronchiectasis, and no overlapping asthma/COPD; documented airway clearance; greater than two exacerbations requiring antibiotics therapy in the last 12 months; and must be approved by pulmonologist.
- Fasenra: Updated age to 6 years and older with severe asthma, and with an eosinophilic phenotype.

The following medications have been recently added/changed to the MaineCare PDL as ***non-preferred*** and will require prior authorization:

• Beizray	• Jascayd	• Otulfi
• Bildyos	• Jobevne	• Phyrago
• Hernexeos	• Keytruda Qlex	• Tyruko
• Ibtrozi	• Kirsty	• Yutrepia
• Inluriyo	• Modeyso	

The following ***non-preferred with criteria*** medications have been added/updated to the MaineCare PDL:

- Airsupra: New prior authorization criteria that include the patient is aged ≥ 18 , AND the patient has had a documented side effect or allergy, AND treatment failure/intolerance or contraindication to Symbicort and Dulera SMART therapy, AND the patient is unable to use albuterol and budesonide separately.
- Anzupgo: Preferred drugs also indicated for this condition, including topical steroids, cyclosporin AND calcineurin inhibitors must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

Limitations of use of Anzupgo in combination with other JAK inhibitors or potent immunosuppressants is not recommended.

- Avtozma: a biosimilar to Actemra. Additional criteria are listed on the Rheumatoid Arthritis Prior Authorization form.
- Bilprevda: a biosimilar to Xgeva. Previous trial of Xgeva or intolerable side effects required before non-preferred biosimilar will be approved.
- Blujepa: For the treatment of patients ≥ 12 years of age.
- Brekiya: Preferred drugs must be tried within the Migraine therapy category and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
- Brynovin: In addition to tried and failed Preferred agents, Brynovin requires tried and failed Non-Preferred agent Zituvio.
- Dawnzera: For the treatment of patients ≥ 12 years of age.
- Ekterly: For the treatment of patients ≥ 12 years of age.
- Exxua: Criteria includes referred drugs (including failure of at least one preferred SSRI, one SNRI and one non-SSRI/SNRI) must be tried for at least 4 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. For the treatment of patients ≥ 18 years of age.

- Otezla XR: For the treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.
- Rhapsido: for chronic spontaneous urticaria. Must have had an inadequate clinical response of at least 14-days with at least two different second-generation antihistamines at four times standard dose. Must be prescribed by or in consultation with either allergist/immunologist, dermatologist, pulmonologist, or otolaryngologist. Must continue use of second-generation antihistamine.
- Sephience: For adults and pediatric patients one (1) month of age and older who have tried and failed or have a contraindication or intolerance to Sapropterin Dihydrochloride products.
- Wayrilz: Clinical PA to establish diagnosis and medical necessity. Baseline platelet count is less than 30,000/mcL and prescribed in consultation or by a hematologist/oncologist.
- Zurnai: For the treatment of adult and pediatric patients \geq 12 years of age.

Pharmacy Helpdesk Hours and Emergency Supply Protocol

Our Pharmacy Helpdesk is here to support you with any questions or claims assistance you may have. The operating hours are Monday to Friday from 8:00 AM to 5:00 PM. For after-hours assistance, our on-call availability is from 5:00 PM to 8:00 PM on weekdays, and from 8:00 AM to 8:00 PM on Saturdays, Sundays, and holidays.

For after-hours emergency claims, please call the Help Desk at 888-420-9711 and request to page our on-call staff. This ensures that urgent issues are addressed promptly, even outside of regular Help Desk hours. In a situation where a pharmacy needs assistance outside of the Help Desk operating and on call hours, a 196 override may be placed in the PA field for many medications. This will allow members to receive an emergency 4-day supply of their medication.

We hope this information helps you provide the best possible service to our members.