DC MEDICAID
FEE FOR SERVICE
DRUG UTILIZATION
REVIEW (DUR)

DHCF
Department of Health Care Finance

DC MEDICAID
PHARMACY &
THERAPEUTICS
(P&T) CORNER

Winter ISSUE 4

PHARMACY & THERAPEUTICS CORNER

Next P&T Meeting: 03/05/2026 @ 2pm

The last DC Medicaid Fee For Service (FFS) P&T Committee was held on December 4th, 2025. You may track updates of DC FFS Preferred Drug List (PDL) at District of Columbia Medicaid | Home. The public session of the quarterly P & T Committee is open to all. Visit the Prime Therapeutics DC FFS Provider Website to view all previous agendas, and meeting notices. The March meeting notice will contain registration instructions to attend the P&T public session as well as how to provide materials and/or make a presentation.

In December, the P&T Committee recommended to make the HIV/AIDs combination agents Triumeq (abacavir/dolutegravir/lamivudine) and Juluca (dolutegravir/rilpivirine) non-preferred. With this to become effective with the March PDL update to give prescribers and patients time to adjust.

Preferred alternatives to these combination products include Tivicay (dolutegravir) and abacavir/lamivudine for Triumeq, and Tivicay (dolutegravir) and Edurant (rilpivirine) for Juluca. With access to Juluca to be grandfathered for current patients so that the two-drug combination is primarily intended for new patients. These changes will alter regimens from one tablet once daily to two tablets once daily.

DC FFS OPIOID TRENDS SINCE THE 2022 CDC GUIDELINES

The latest Centers for Disease Control and Prevention (CDC) Clinical Practice Guideline for Prescribing Opioids for Pain was published on November 3rd, 2022 to offer a patient-centered flexible approach. This guideline includes an intermodular/ interdisciplinary approach with suggestions of improved communication between clinicians and patients. Overall, this approach focuses on individualized patient needs and goals with the following: appropriateness to initiate opioids for pain, opioid selection and dosage, duration of opioid and follow-up, risk and potential harm assessment.

The CDC guidelines identify the duration of pain as acute (<1 month), subacute (1 -3 months), and chronic (> 3 months). Optimal nonopioid therapies are at least as effective as opioids for most types of acute pain. It is appropriate for opioids to be considered for acute pain when benefits outweigh risks. Common acute pain examples are low back pain, musculoskeletal injuries, dental pain, kidney stone pain, headaches, pain related to minor surgeries, etc. Nonopioid pharmacologic therapies whether topical or oral are just as important to utilize as nonpharmacologic therapies such as ice, heat, elevation, or exercise. Nonopioid therapies are also preferred for subacute and chronic pain.

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Additional Info: Live.Long.DC. (End DC's Opioid Epidemic)
Opioid Overdose Dashboard

Noninvasive nonpharmacologic approaches to manage pain such as acupuncture, spinal manipulation, Nerivio REN wearable, physical therapy, medical massage, mindfulness-based stress reduction, yoga, and multidisciplinary rehabilitation are covered by DC Medicaid. Pain management which includes behavioral health support with a multimodal and multidisciplinary approach is critical to positive health outcomes.

Shared clinical decision making with the use of opioids should include realistic benefits, known risks, treatment goals, harm reduction, and how opioid therapy will be discontinued if benefit does not continue to outweigh risks. During initiation of opioid therapy as part of a pain management plan, clinicians should prescribe the lowest effective dosage of immediate-release opioids.

**From 2020 to 2021, many patients switched from FFS to MCOs. Also, PAs were not required during the COVID Public Health Emergency.*

Year	#Paid Claims	#Patients	Avg MME/ Day/Claim
2020	15,786	3,268	32.01
2021	4,454	763	37.76
2022	4,057	617	30.08
2023	3,930	571	35.59
2024	3,789	552	38.08
2025	3,922	582	41.04

Table #1: 2020 -2025 Paid Opioid Claims for FFS Members

Year	Drug	#Paid Claims
2020	Oxycodone-APAP 5-325mg	3,493
2021	Oxycodone-APAP 5-325mg	937
2022	Oxycodone-APAP 5-325mg	790
2023	Oxycodone (IR) 5mg	684
2024	Oxycodone (IR) 5mg	724
2025	Oxycodone (IR) 5mg	702

Table #2: 2020-2025 Top #1 Paid Opioid Drug for FFS Members

Year 2025	#Paid Claims 50-89.9 MME	#Paid Claims 90-120 MME	#Paid Claims >120 MME
Q1	157	97	94
Q2	140	89	89
Q3	122	86	76
Q4	132	99	58

Table #3: FFS 2025 # of Paid Opioid Claims/ Quarter by MME

Year	#Paid Naloxone Claims
2020	469
2021	173
2022	249
2023	273
2024	275
2025	359

Table #4: Number of Paid Naloxone Claims for FFS Members **Please note: All naloxone claims except one (naloxone 8mg in 2023) from 2020 to 2025 were for 4mg. All dosages of naloxone are preferred by DC Medicaid.*

The quantity of opioids needed for acute pain should be no greater than the expected duration of severe pain. Within 1 – 4 weeks of starting opioids for subacute or chronic pain, benefits and risk should be reevaluated. It is also critical that reversible root causes of chronic pain are addressed.

In practice, clinicians should be aware that clinical evidence reviews and studies determined opioids are associated with small improvements in short-term (1 to <6 months) pain and function compared with placebo, with reduced effectiveness over time (3-6 vs. 1-3 months).

The DC DUR Board reviews FFS opioid data for claim count, day supply, average MME, top pharmacies, and top prescribers each quarter (i.e. See table #2). Within the past couple of years, the data is mostly consistent with a quarter over quarter downward trend of opioid claim count and day supply for the FFS patient population.

The District FFS Provider Manual references the MME policy/ program which was created to decrease the risk of opioid daily dosages that can be medically harmful or fatal. Prior authorizations (PAs) are required for opioid prescriptions greater than 90 MME and/or a 7-day supply (see table #3).

Strategies to mitigate risk, including but not limited to offering naloxone, should be established. Also, remind patients to check expiration dates of stored naloxone. In the FFS population, the number of naloxone claims are minuscule when compared to the number of paid opioid claims year over year (see tables # 1 & 4).

When prescribing opioid therapy, the CDC guidelines recommend reviewing the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) to evaluate dosages or combinations that increases overdose risk. In DC however, PDMP registration and utilization is mandatory for prescribers and dispensers of prescription opioids/ controlled substances during patient care. More details about the PDMP program and mandatory PDMP query can be found on the DC DoH website.

While assessing risks and reviewing patient history, clinicians should use extreme caution with prescribing concomitant opioid and benzodiazepine therapies. The DC DUR Board reviews high risk opioid concomitant therapies monthly. The category that consistently has the highest average MME each month is benzodiazepines and opioids. There was an increase from 2024 to 2025 of the total average MME of benzodiazepines and opioid claims (2024: 65 MME vs 2025: 89 MME).

The CDC's last but not least important recommendation is to offer patients evidence-based medications to treat opioid use disorder. Medication-Assisted Treatment (MAT) drug products are covered for DC Medicaid patients and discussed in section 4.3 of the provider manual.