

**PHARMACY & THERAPEUTICS CORNER**  
**Next P&T Meeting: 09/03/2026 @ 2pm**

*The quarterly DC Medicaid Fee For Service (FFS) P&T Committee meeting was held June 4<sup>th</sup>.*

*The drug class, Ophthalmic Anti-inflammatories/ Immunomodulators has been renamed Dry Eye Agents with changes recommended to its preferred agents. Significant recommendations were also made for the Acne, Anti-migraine, Epinephrine, and Smoking Cessation Agents. Plus, preferred agents were added for a new drug class, Immunomodulators for Asthma.*

*During the executive session, the committee also recommended changes to preferred Cytokine and CAM Antagonists prior to the September review that include newly approved interchangeable biosimilars and other changes.*

*The meeting agenda and the updated Preferred Drug List (PDL) with the reviewed drug classes can be found at the [District of Columbia Medicaid Provider PDL Website](#).*

## Heart Failure (HF)

Approximately 6.7 million Americans aged ≥20 years have heart failure (HF), which is projected to reach 11.4 million by 2050. The lifetime risk of HF is approximately 24%, affecting nearly 1 in 4 individuals. HF disproportionately affects Black individuals, who experience higher incidence, prevalence, and mortality rates than other racial and ethnic groups.

In recent decades, the definition of HF has progressed with increased understanding in its pathophysiology, biomarkers, and imaging technologies. Early definitions were mostly based on clinical symptoms and signs, whereas updated definitions focus more on structural and functional cardiac abnormalities. These modern changes have improved diagnostic accuracy and targeted therapeutic treatment, essentially improving patient outcomes.

The discussion of HF is aligned with the [2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure](#). Clinicians should maintain a broad differential diagnosis and recognize that HF is not defined solely by a reduced ejection fraction. Less typical presentations such as

high-output heart failure (cardiac index > 4 L/min/m<sup>2</sup>), as well as non-cardiac conditions that can mimic HF (i.e. severe anemia, COPD), should be considered and systematically evaluated to ensure accurate diagnosis and appropriate management.

Guideline-directed medical therapy (GDMT) is primarily determined by left ventricular ejection fraction (LVEF), symptom burden, the New York Heart Association (NYHA) functional class, and individual patient characteristics. Key factors influencing medication selection and titration include blood pressure, renal function, serum potassium levels, heart rate, relevant comorbid conditions, and tolerance of therapy. These parameters help optimize evidence-based therapies while minimizing side/adverse effects such as dizziness, bradycardia, hypotension, hyperkalemia, cough, renal impairment, etc. The AHA/ACC staging system helps clinicians identify the stage and severity of HF, guide treatment, and prevent disease progression.

**Stage A (HF Risk)** includes patients who have one or more risk factors for HF (e.g., hypertension, diabetes, genetic variant for cardiomyopathy, atherosclerosis, obesity, or exposure to cardiotoxic agents) but who have no symptoms or signs of HF, structural or functional cardiac abnormalities, or abnormal biomarkers. The

**Table #1 2025 Sample of Various HF Diagnoses in FFS Patients**

| #Patients | ICD-10  | Condition Description                                 |
|-----------|---------|-------------------------------------------------------|
| 334       | I50.9   | Heart Failure, unspecified                            |
| 257       | I11.0   | Hypertensive heart disease w/ Heart Failure           |
| 166       | I50.22  | Chronic systolic (congestive) Heart Failure           |
| 114       | I50.30  | Unspecified diastolic (congestive) Heart Failure      |
| 113       | I50.32  | Chronic diastolic (congestive) Heart Failure          |
| 69        | I50.23  | Acute on chronic systolic (congestive) Heart Failure  |
| 64        | I50.33  | Acute on chronic diastolic (congestive) Heart Failure |
| 63        | I50.21  | Acute systolic (congestive) Heart Failure             |
| 38        | I50.31  | Acute diastolic (congestive) Heart Failure            |
| 18        | I50.810 | Right Heart Failure, unspecified                      |
| 9         | I50.82  | Biventricular Heart Failure                           |
| 8         | I50.84  | End stage Heart Failure                               |
| 1         | I50.83  | High output Heart Failure                             |

primary goal of Stage A is to aggressively manage and reduce cardiovascular risk factors while promoting healthy lifestyle habits to prevent structural/ functional cardiac abnormalities which can lead to symptomatic HF. Hypertension (HTN), one of the most common risk factors for HF, can be effectively managed by achieving guideline-directed blood pressure targets through evidence-based therapies, such as angiotensin-converting enzyme inhibitors (ACE-I) and angiotensin receptor blockers (ARBs). Early use of sodium-glucose cotransporter-2 (SGLT2) inhibitors may also be appropriate, particularly for patients with comorbid type 2 diabetes or chronic kidney disease. The [DC Health Cardiovascular Program](#) supports the [Million Hearts®](#) Initiative by preventing and managing heart disease, diabetes, obesity, and related risk factors. This program expands access and promotes evidence-based lifestyle programs, while partnering with health systems to improve the detection and management of HTN/ prediabetes.

**Table #2: Covered Benefits**

| #Patients                                          |
|----------------------------------------------------|
| Medical Nutrition Therapy (MNT) with a Dietitian   |
| Cardiac Rehabilitation                             |
| Some Complementary and Alternative Medicines (CAM) |
| Implantable Cardioverter Defibrillator (ICD)       |
| Left ventricular assist device (LVAD)              |
| Transcatheter Aortic Valve Replacement (TAVR)      |
| Transcatheter Aortic Valve Implantation (TAVI)     |

**Stage B (Pre-HF)** represents structural/ functional cardiac abnormalities, or elevated biomarkers (BNP/ troponin) with no historical or present HF symptoms. The primary goals of Stage B are to halt structural cardiac remodeling, lower elevated intracardiac filling pressures, and reduce elevated myocardial stretch/injury markers to prevent the transition to symptomatic HF Stages C/D. For example, ACE-I or ARBs and beta- blockers in asymptomatic HF with reduced LVEF (HFrEF ≤ 40%) after acute myocardial infarction can improve survival outcomes by blocking the renin-angiotensin-aldosterone system (RAAS) and reducing the adrenergic tone of the sympathetic nervous system (SNS), respectively which can halt maladaptive remodeling.

**Stage C (Symptomatic HF)** represents structural heart disease with present or past symptomatic HF that manifest with systemic/ pulmonary congestion driven by chronic or prolonged RAAS/ SNS activation which leads to decompensated myocardial mechanics (reduced contractility, stiffness, loss of synchrony).

The primary therapeutic goals are to:

- **Relieve congestion and symptoms** using loop diuretics, with thiazide-type diuretics added when appropriate. Providers should monitor the patient's response because diuretic effectiveness may plateau at higher doses.
- **Optimize GDMT** to further suppress RAAS and SNS activation, thereby preventing clinical deterioration through stabilization of ventricular remodeling and reduction of morbidity and mortality.
- **Reduce the risk of sudden cardiac death** through device therapy (ICD, LVAD, cardiac pacemaker, etc.) when the patient meets guideline-based eligibility criteria.
- **Reduce hospital stays and improve quality of life and survival** through appropriate medical therapy, monitoring, and management of comorbid conditions.

GDMT highlights the four pillars for HFrEF (see Table #3) and provides guidance on other LVEF categories such as HF with preserved ejection fraction (HFpEF= LVEF ≥50%). HFpEF treatment focuses on SGLT2 inhibitors, diuretics for symptom control, consideration of MRAs (and sometimes ARNIs), and treatment of comorbidities, rather than the fixed four-pillar regimen used for HFrEF.

**Stage D (Advanced HF)** is defined by persistent/progressive symptoms despite optimized GDMT. Management should include important **early referral** to an advanced heart failure center. In Washington, DC, certified centers are located at MedStar Washington Hospital Center and George Washington University Hospital. The primary goal(s) of Stage D are:

- **Mechanical circulatory support** when eligible
- **Inotropic therapy** in selected patients
- **Heart transplantation** if appropriate
- **Palliative and supportive care** focused on symptom management and quality of life

*Table #3: HFrEF Four-Pillar GDMT Patient-Friendly Language*

| Tx Class                     |  | Patient Prescription Education and Literacy Communication of the Four Pillars for HFrEF                                                                                                                                                                                                                                                               |  |
|------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>SGLT2 inhibitors</b>      |  | Removes extra sugar, salt, and fluid which can lower blood pressure and improve energy. Also protects your heart and kidneys while reducing the risk of hospitalization even if you do not have diabetes.                                                                                                                                             |  |
| <b>Beta Blockers</b>         |  | Lowers blood pressure and block stress hormones that can make your heartbeat too fast and hard. It also helps your heart muscle heal and recover strength over time along with reducing hospital stays.                                                                                                                                               |  |
| <b>ARNIs, ACE-I, or ARBs</b> |  | Eases blood flow and lower stress, so your heart muscles do not have to push as hard, and blocks stress hormones that make HF worse. Also helps your heart heal and stop growing too large and changing shape, reduces hospital stays, and helps you live longer.                                                                                     |  |
| <b>MRAs</b>                  |  | Blocks bad hormones like aldosterone from overworking your heart. Reduces fluid buildup that can swell your body by helping your kidneys remove extra salt and water. Also, it protects your heart muscle from getting stiff or scarred. It reduces hospital stays and is a team player with your other heart medications to protect your whole body. |  |

**PRACTICE NUGGETS:** Clinicians should be aware of covered benefits for FFS patients related to HF management and treatment in Table #2. Evidence-based counseling strategies are recommended to improve medication adherence, including the use of plain, patient-friendly language (see an example in Table 3). Medication adherence is a critical component of effective HF management because it helps reduce hospitalizations and improve survival. Patients may discontinue medications when they do not understand their purpose or mistakenly believe a medication is intended to treat a condition they do not have. For example, a patient with HF may stop taking an ACE-I because they have never been diagnosed with HTN. Providing clear, patient-centered, evidence-based education sensitive to health literacy levels or in the patient’s preferred language in addition to counseling can help prevent these misunderstandings and support long-term therapeutic adherence.

Providers should routinely review medication adherence at follow-up visits; reconcile medications after hospitalizations and transitions of care; assess affordability and access to medications; and engage prescribers, pharmacists, nurses, caregivers, and other members of the multidisciplinary team when additional support is needed. Patients should also be taught how to recognize worsening HF symptoms, monitor their weight when appropriate, and understand when to contact their healthcare team.

Clinicians should assess and address system barriers and social determinants of health to improve HF care and the use of GDMT. Fewer than 25% of eligible patients receive all recommended medications. Providers should routinely assess whether eligible patients are receiving appropriate GDMT, whether medications have been titrated to maximally tolerated doses, and whether barriers to initiation or continuation have been addressed. Early initiation and timely titration, when clinically appropriate, are recommended. Optimal GDMT could save an estimated 1.19 million lives globally each year.