Quarterly Pharmacy Provider Forum

Department of Health Care Finance

Tuesday, December 16th 1 - 3PM

Wednesday, December 17th 11 - 1PM

AGENDA

- Welcome
- Introductions
- DHCF Updates
- MCO Updates
- Contact Information
- Open Discussion

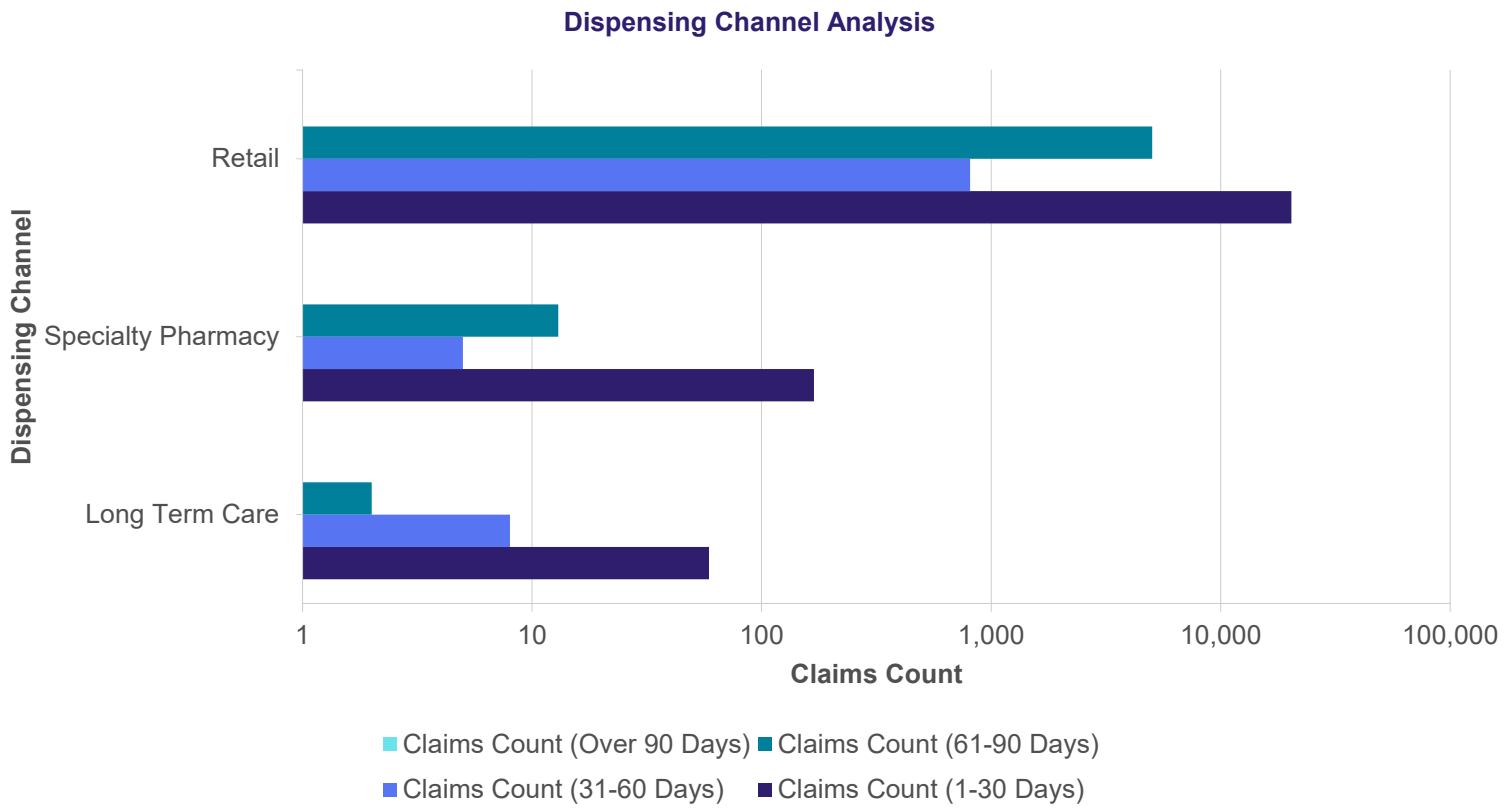
FFS 4th Quarter highlights – Alliance ICP Program

* Effective October 1, 2025, The Health Care Alliance program and the Immigrant Children's Program (ICP) merged into one program called the Health Care Alliance Program for Adults and Children.
*
  Managed Care Plans (MCP) prior authorizations converted to Fee for Service till 12/31/2025.

Alliance Claims Trending

Metric	Oct 2025 to Dec 14th, 2025
Claim Count	26,424
Claim Count - Brand	1,868
Claim Count - Generic	24,556
Generic Substitution Rate	99.60%
Membership Total	26,769
Multi-Source Generic %	92.93%
Retail % ($)	93.13%
Single-Source Brand %	6.70%
Utilizers	5,419
Utilizers %	20.24%

Dispensing Chanels



Pharmacy Providers not enrolled

Claims reject code 40 – Provider not contracted with DHCF

Provider enrollment is through Maximus www.dcpdms.com

Link above contains information on how to enroll or reenroll in scenarios such as reactivation of terminated providers, enrollment of MCO only provider to FFS providers or new providers

Alliance ICP Program

Any questions, issues or concerns?

DC-FFSProviderRelations@primetherapeutics.com

Pharmacy Audit Process

Pharmacy Audit Process

* Ensures compliance with Medicaid provider agreement.
* On-site and desk audits Implemented October 1, 2024
* Provide continuing education and enhanced support to Medicaid enrolled pharmacies
* Reinforce pharmacy responsibility to complete and distribute triplicate form copies when a medication is denied for a beneficiary

Triplicate Notice Compliance Audit Trend 3Q2025

Audit Result	NPI #
FAIL	**16 (38%)**
No required signs or carbon copy forms.	
Partial compliance had required signs but no carbon copy forms.	
Poster not visible	
The pharmacy had one sign but had the carbon copy forms.	
MISCELLANEOUS	**2**
This pharmacy is closed.	
PASS	**24 (57%)**
Grand Total	**42**

Pharmacy Poster

THIS IS AN IMPORTANT NOTICE TO DC MEDICAID RECIPIENTS…

Did you get your MEDICINE today?

If you did not receive your medication, please speak to your pharmacist to answer your questions and resolve your concerns.

If you still have questions or concerns and you are enrolled in any of the following health plans, please contact your health plan at one of the following numbers:

- **AmeriHealth Caritas DC** - 1.800.408.7511
- **Amerigroup DC**- 1.833.235.2029
- **MedStar Family Choice DC** - 1.888.404.3549
- **Health Services for Children with Special Needs (HSCSN)** - 202.467.2737 or 1.866.937.4549

If you are enrolled in the DC Medicaid Fee for Service Program and did not receive your medication, call the Fee for Service Medicaid Pharmacy Call Center at 1.800.273.4962.

You can **ask your pharmacist for a 3-day supply of medicine** until the issue that prevented you from getting your medication today is resolved.

You can request a fair hearing if you think your request for medication has been wrongfully denied or reduced. To request a hearing:

- Call the DHCF Ombudsman at 202.724.7491 or email healthcarecombudsman@dc.gov;
- Call the Office of Administrative Hearings at 202.442.9094;
- Or visit 441 4th Street, NW, Suite 250 North, Washington, DC 20001.

DHCF
Department of Health Care Finance

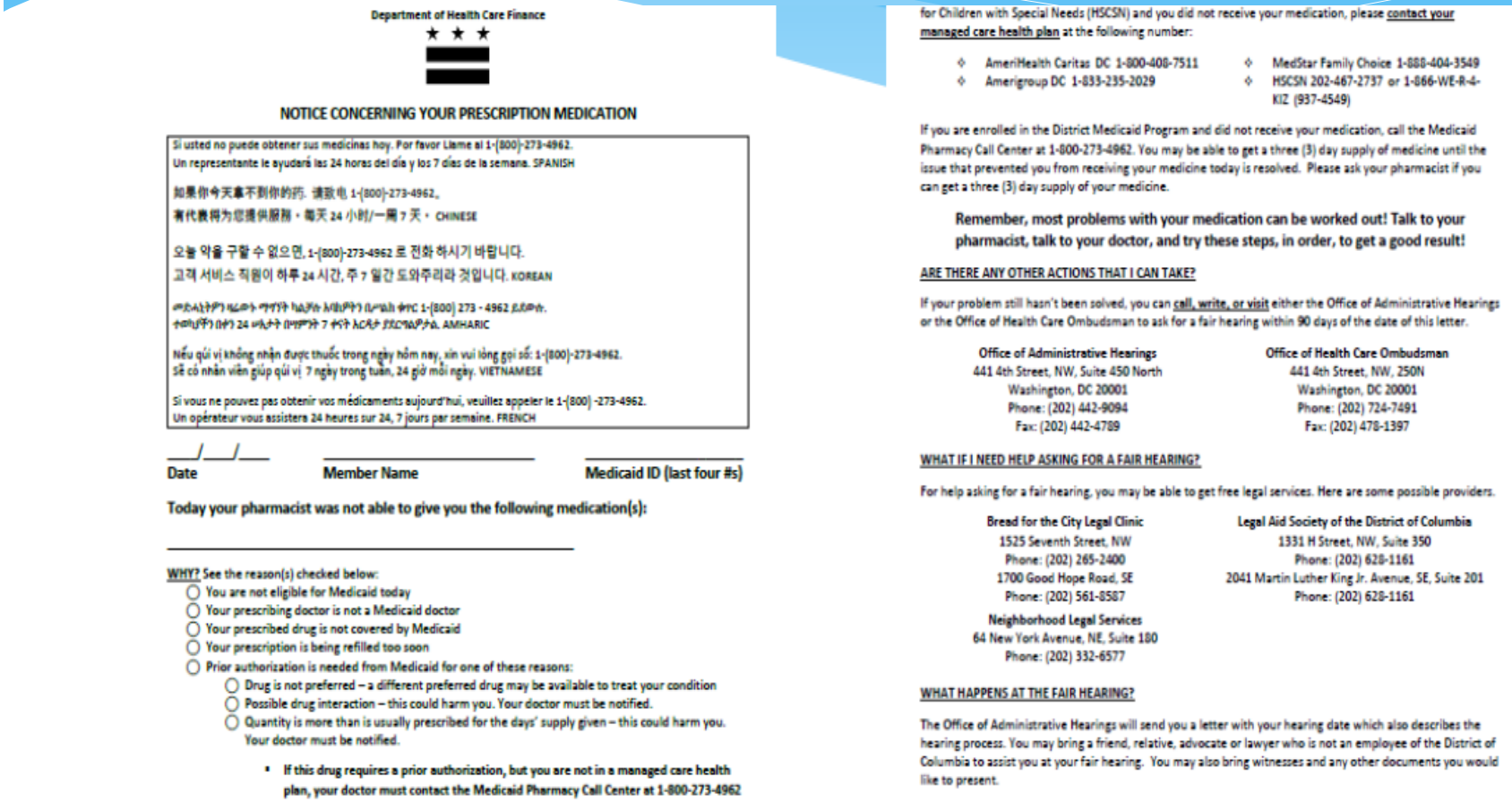
GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Beneficiary Triplicate Notice Form Request

Replenishment request form is available on FFS providers portal https://www.dc-pbm.com/

* Select Provider Home, under **Frequently Requested Documents Triplicate** Form Request – Beneficiaries Notice
* Fillable form complete, save a nd send copy to email - DCMedicaidTriplicateForms@primetherapeutics.com

Beneficiary Triplicate Notice Form



Department of Health Care Finance

NOTICE CONCERNING YOUR PRESCRIPTION MEDICATION

Si usted no puede obtener sus medicinas hoy. Por favor Llame al 1-(800)-273-4962.
Un representante le ayudará las 24 horas del día y los 7 días de la semana. SPANISH

如果你今天拿不到你的药. 请致电 1-(800)-273-4962。
有代表将为您提供服務，每天 24 小时/一周 7 天。 CHINESE

오늘 약을 구할 수 없으면, 1-(800)-273-4962 로 전화 하시기 바랍니다.
고객 서비스 직원이 하루 24 시간, 주 7 일간 도와주리라 것입니다. KOREAN

መድኃኒትዎን ዛሬውኑ ማግኘት ካልቻሉ እባክዎትን በ-ስልክ ቁጥር 1-(800) 273 - 4962 ይደውሉ.
ተወካዮች በቀን 24 ሰዓታት በሳምንት 7 ቀናት አርዳታ ያደርጎልዎታል. AMHARIC

Nếu qúi vị không nhận được thuốc trong ngày hôm nay, xin vui lòng gọi số: 1-(800)-273-4962.
Sẽ có nhân viên giúp qúi vị 7 ngày trong tuần, 24 giờ mỗi ngày. VIETNAMESE

Si vous ne pouvez pas obtenir vos médicaments aujourd'hui, veuillez appeler le 1-(800) -273-4962.
Un opérateur vous assistera 24 heures sur 24, 7 jours par semaine. FRENCH

___/___/___ Date | Member Name | Medicaid ID (last four #s)

Today your pharmacist was not able to give you the following medication(s):

_____

WHY? See the reason(s) checked below:

- ◯ You are not eligible for Medicaid today
- ◯ Your prescribing doctor is not a Medicaid doctor
- ◯ Your prescribed drug is not covered by Medicaid
- ◯ Your prescription is being refilled too soon
- ◯ Prior authorization is needed from Medicaid for one of these reasons:
  - ◯ Drug is not preferred – a different preferred drug may be available to treat your condition
  - ◯ Possible drug interaction – this could harm you. Your doctor must be notified.
  - ◯ Quantity is more than is usually prescribed for the days' supply given – this could harm you. Your doctor must be notified.

▪ **If this drug requires a prior authorization, but you are not in a managed care health plan, your doctor must contact the Medicaid Pharmacy Call Center at 1-800-273-4962**

for Children with Special Needs (HSCSN) and you did not receive your medication, please **contact your managed care health plan** at the following number:

- ✧ AmeriHealth Caritas DC 1-800-408-7511
- ✧ Amerigroup DC 1-833-235-2029
- ✧ MedStar Family Choice 1-888-404-3549
- ✧ HSCSN 202-467-2737 or 1-866-WE-R-4-KIZ (937-4549)

If you are enrolled in the District Medicaid Program and did not receive your medication, call the Medicaid Pharmacy Call Center at 1-800-273-4962. You may be able to get a three (3) day supply of medicine until the issue that prevented you from receiving your medicine today is resolved. Please ask your pharmacist if you can get a three (3) day supply of your medicine.

Remember, most problems with your medication can be worked out! Talk to your pharmacist, talk to your doctor, and try these steps, in order, to get a good result!

ARE THERE ANY OTHER ACTIONS THAT I CAN TAKE?

If your problem still hasn't been solved, you can **call, write, or visit** either the Office of Administrative Hearings or the Office of Health Care Ombudsman to ask for a fair hearing within 90 days of the date of this letter.

Office of Administrative Hearings
441 4th Street, NW, Suite 450 North
Washington, DC 20001
Phone: (202) 442-9094
Fax: (202) 442-4789

Office of Health Care Ombudsman
441 4th Street, NW, 250N
Washington, DC 20001
Phone: (202) 724-7491
Fax: (202) 478-1397

WHAT IF I NEED HELP ASKING FOR A FAIR HEARING?

For help asking for a fair hearing, you may be able to get free legal services. Here are some possible providers.

Bread for the City Legal Clinic
1525 Seventh Street, NW
Phone: (202) 265-2400
1700 Good Hope Road, SE
Phone: (202) 561-8587

Legal Aid Society of the District of Columbia
1331 H Street, NW, Suite 350
Phone: (202) 628-1161
2041 Martin Luther King Jr. Avenue, SE, Suite 201
Phone: (202) 628-1161

Neighborhood Legal Services
64 New York Avenue, NE, Suite 180
Phone: (202) 332-6577

WHAT HAPPENS AT THE FAIR HEARING?

The Office of Administrative Hearings will send you a letter with your hearing date which also describes the hearing process. You may bring a friend, relative, advocate or lawyer who is not an employee of the District of Columbia to assist you at your fair hearing. You may also bring witnesses and any other documents you would like to present.

FFS Web Portal Reminders

Home | DC Pharmacy Programs

* Access to FFS prior authorization forms
* Alliance formulary and reference generic only formulary
* Access to frequently requested document such as
  * Diabetic Supply List
    * DCRx_Diabetic_Supply_Program_Listing.pdf
  * Preferred Drug List "Formulary"
    * DCRx_PDL_listing.pdf

FFS – Preferred Drug List Updates

December 2025 FFS P&T Meeting changes effective 3/2026 – Quarterly Changes

HIV/AID Class –Impact entire population (FFS/MCO)

Changing from preferred to Non preferred

Triumeq

* Preferred - Use 2 agent Tivicay and generic Abacavir/Lamivudine

Juluca

* current members to be grandfathered

DHCF Contact Information

* Charlene Fairfax, RPh, CDE
  * Senior Pharmacist
  * Charlene.fairfax@dc.gov or 202-442-9076
* Gidey Amare, RPh, MS
  * Pharmacist
  * Gidey.amare@dc.gov or 202-442-5956
* Tayiana Reed, Pharm D, MS, AAHIVP, RPH
  * Pharmacist
  * Tayiana.reed1@dc.gov or 202-442-478-1415

Providers Contact Information

Provider Enrollment – Maximus

* Nikki Kittrell, Project Director
  * MarthaDKittrell@maximus.com
  * 202-499-3396

Prime Therapeutics FFS Provider Relations

* DC-FFSProviderRelations@primetherapeutics.com

MedStar Family Choice

DISTRICT OF COLUMBIA

It's how we treat people.

December 16th & 17th , 2025

Pharmacy Provider Forum

District of Columbia Healthy Families

District of Columbia Healthcare Alliance

Mina Tawfeik, PharmD

Health Plan Pharmacist, MFC DC

Mina.Tawfeik@medstar.net

Pharmacy Team Members

Health Plan Pharmacist, MFC DC
Mina Tawfeik, PharmD
- Mina.Tawfeik@medstar.net

Diamond Lewis, CPhT
- Diamond.Lewis@medstar.net

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Agenda

1. Safety moment
2. Prior Authorization
3. Quick Topics
4. MFC-DC Formulary Changes Effective October 1, 2025
5. POS Beneficiary Notice Forms
6. Provider Issues
7. Questions

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Safety Moment

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Case

Situation:	• An Enrollee was dispensed concurrent Entresto (sacubitril/valsartan) and losartan RXs multiple times
Background:	• Entresto is a replacement for ACE-I or ARB medication; these medications should not be used concurrently. • When switching from an ACE-I a 36-hour washout period is needed; no washout period is needed when switching from an ARB and patients can start Entresto when their next dose is due
Assessment:	• Entresto and losartan RXs were dispensed on the same day from the same pharmacy; TD alert did fire during the dispensing process • TD alert is not set up to reject for anti-HTN medications because use of multiple anti-HTN meds is often clinically needed • Patient outreach confirmed the patient did not take both medicines together
Recommendations:	• Outpatient pharmacists should carefully assess TD alerts for Entresto prescriptions to make sure they are not also being dispensed an ACE-I or ARB medication

Prior Authorizations

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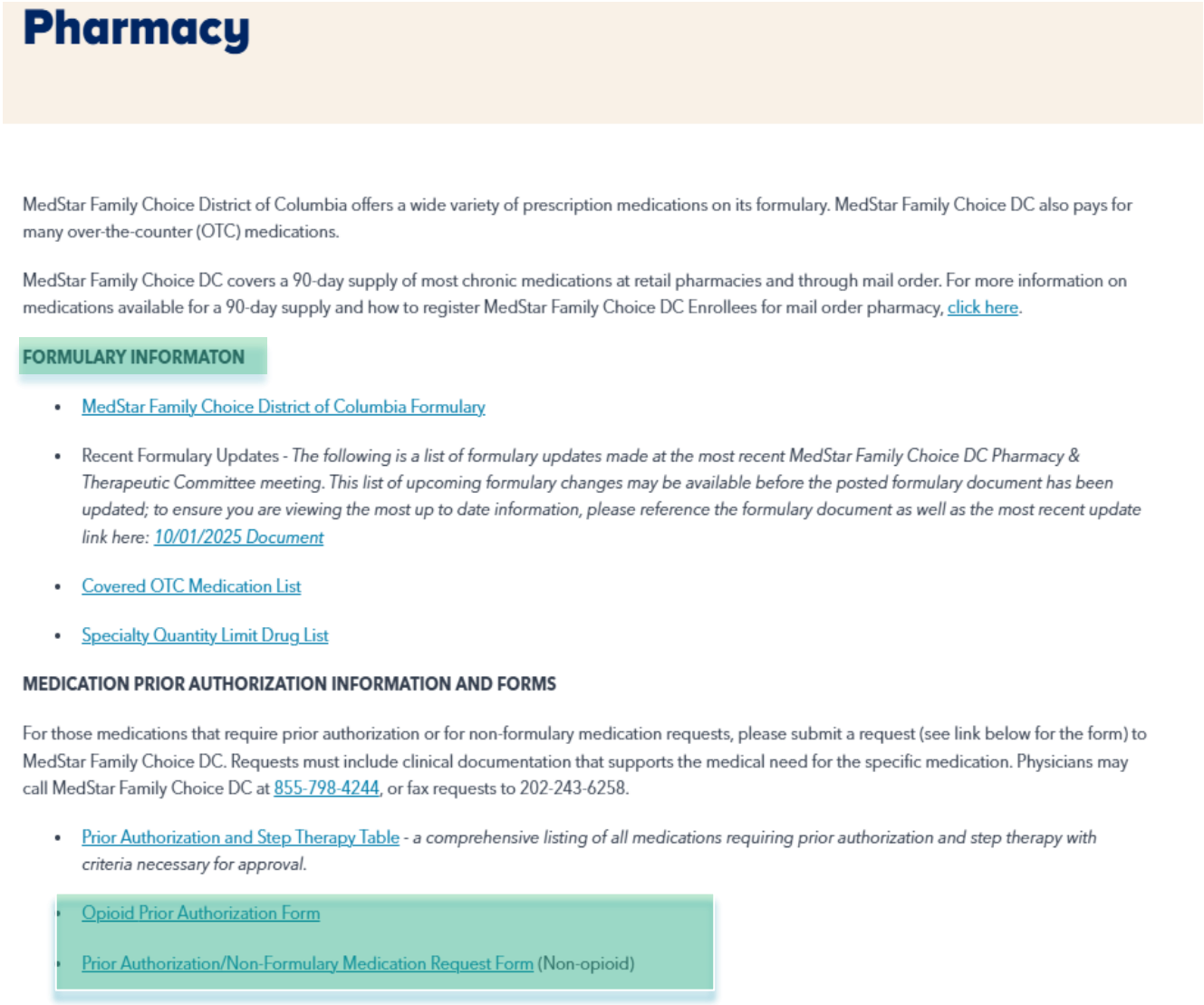
MFC-DC Pharmacy Website

Website address: https://www.medstarfamilychoicedc.com/providers/pharmacy

Our website is the most up-to-date, comprehensive source of MFC-DC Pharmacy information.



Pharmacy

MedStar Family Choice District of Columbia offers a wide variety of prescription medications on its formulary. MedStar Family Choice DC also pays for many over-the-counter (OTC) medications.

MedStar Family Choice DC covers a 90-day supply of most chronic medications at retail pharmacies and through mail order. For more information on medications available for a 90-day supply and how to register MedStar Family Choice DC Enrollees for mail order pharmacy, click here.

FORMULARY INFORMATON

- MedStar Family Choice District of Columbia Formulary
- Recent Formulary Updates - *The following is a list of formulary updates made at the most recent MedStar Family Choice DC Pharmacy & Therapeutic Committee meeting. This list of upcoming formulary changes may be available before the posted formulary document has been updated; to ensure you are viewing the most up to date information, please reference the formulary document as well as the most recent update link here: 10/01/2025 Document*
- Covered OTC Medication List
- Specialty Quantity Limit Drug List

MEDICATION PRIOR AUTHORIZATION INFORMATION AND FORMS

For those medications that require prior authorization or for non-formulary medication requests, please submit a request (see link below for the form) to MedStar Family Choice DC. Requests must include clinical documentation that supports the medical need for the specific medication. Physicians may call MedStar Family Choice DC at 855-798-4244, or fax requests to 202-243-6258.

- Prior Authorization and Step Therapy Table - *a comprehensive listing of all medications requiring prior authorization and step therapy with criteria necessary for approval.*
- Opioid Prior Authorization Form
- Prior Authorization/Non-Formulary Medication Request Form (Non-opioid)

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Prior Authorization Process

Complete the corresponding MFC-DC Prior Authorization Request form. Separate forms for:

- General PA/NF medications
- Opioids

✓ Include most recent relevant clinical documentation to support request

✓ Fax complete request (form + clinicals) to the health plan at **202-243-6258**

MedStar Family Choice
DISTRICT OF COLUMBIA

Prior Authorization and Step Therapy Table

Provides additional info for Prior Authorizations. To see info, you would go to:
https://www.medstarfamilychoicedc.com/providers/pharmacy

Once you get to website, scroll down to this section:

MEDICATION PRIOR AUTHORIZATION INFORMATION AND FORMS

For those medications that require prior authorization or for non-formulary medication requests, please submit a request (see link below for the form) to MedStar Family Choice DC. Requests must include clinical documentation that supports the medical need for the specific medication. Physicians may call MedStar Family Choice DC at 855-798-4244, or fax requests to 202-243-6258.

- Prior Authorization and Step Therapy Table - *a comprehensive listing of all medications requiring prior authorization and step therapy with criteria necessary for approval.*
- Opioid Prior Authorization Form
- Prior Authorization/Non-Formulary Medication Request Form (Non-opioid)

Then you click on: Prior Authorization and Step Therapy Table

Once you click on link it will show you Medication Name, Approval Criteria & Submission Requirements and also Additional Consideration & Renewal Criteria.

Example:

Generic Medication (Brand Name) **Bolded** name indicates whether Brand or Generic is Formulary	Approval Criteria & Submission Requirements	Additional Considerations & Renewal Criteria
tirzepatide (**Zepbound**) injection 2.5mg/0.5ml, 5mg/0.5ml, 7.5mg/0.5ml, 10mg/0.5ml, 12.5mg/0.5ml, 15mg/0.5ml *****NOTE: see separate listing with PA criteria for Mounjaro*****	1. Ordered for the **ONLY** covered indication for use: • To treat moderate to severe obstructive sleep apnea (OSA) in adults with obesity. 2. **Cannot be approved for indication of weight management.** 3. Patient age ≥ 18 years. 4. Patient does **NOT** have Type 1 or Type 2 diabetes. 5. Moderate to severe OSA as diagnosed by polysomnography with an apnea-hypopnea index (AHI) ≥ 15 events per hour. Clinical documentation of sleep study results within previous 6 months. 6. BMI ≥ 30 kg/m² 7. Provide current BMI, height, and weight measurements within the last 90 days. 8. May not be concurrently using or taking ANY of the below: • **ANY** GLP-1 or GLP1/GIP combination drug (e.g. Mounjaro, Ozempic, Rybelsus, Saxenda, Soliqua, Trulicity, Victoza, Xultrophy, or Wegovy). • **ANY** DPP4i (alogliptin, Januvia [sitagliptin], Onglyza [saxagliptin], Tradjenta [linagliptin]). • Agents for severe constipation: metoclopramide, Amitiza (lubiprostone), Linzess (linaclotide), Motegrity (prucalopride) or Trulance (plecanatide).	1. **Cannot be approved for indication of weight management.** 2. Submission of BMI, height and weight within previous 90 days. NOT eligible for renewal if BMI < 30 kg/m2. 3. If Mounjaro therapy has occurred for greater than 12 months, a repeat sleep study confirming moderate to severe OSA diagnosis is required and annually thereafter. 4. Approval Duration: 6 months.

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Formulary

When looking at formulary it also provides requirements and limits for medications

OTC - Over the counter **PA** - Prior Authorization **QL** - Quantity Limit **ST** - Step Therapy

Drug Name	Requirements/Limits
rifampin caps 150mg, 300mg	
SIRTURO TABS 20MG, 100MG	PA
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	
ALKYLATING AGENTS	
cyclophosphamide caps 25mg, 50mg	
LEUKERAN TABS 2MG	
MYLERAN TABS 2MG	
temozolomide caps 5mg, 20mg, 100mg, 140mg, 180mg, 250mg	
ANTIMETABOLITES	
capecitabine (generic of XELODA) *tabs 150mg, 500mg*	
mercaptopurine tabs 50mg	
methotrexate sodium tabs 2.5mg	
ONUREG TABS 200MG, 300MG	PA, QL (14 tabs every 28 days)
ANTINEOPLASTIC - ANTIBODIES	
LUNSUMIO SOLN 30MG/30ML	PA, QL (2 vials every 21 days)
ZYNLONTA SOLR 10MG	PA
ANTINEOPLASTIC - BCL-2 INHIBITORS	
VENCLEXTA TABS 10MG, 50MG	QL (120 tabs every 30 days)
VENCLEXTA TABS 100MG	QL (180 tabs every 30 days)
VENCLEXTA TAB START PK	QL (starter dose: 1-time fill)
ANTINEOPLASTIC - CELLULAR IMMUNOTHERAPY	
ABECMA INJ	PA
BREYANZI SUSP 70000000CELLS	PA
YESCARTA INJ	PA

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Quick Topics

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RX Processing Reminders

- Formulary preferred insulins :
  - Long-acting glargine – BRAND Lantus, Rezvoglar
  - Rapid-acting – BRAND Novolog

- 3-Day emergency override
  - Available for PA medications *where there is clinical need for urgent access* (sooner than 24 hours)
  - If using, please also initiate PA request process
  - Repeat use for same medication is prohibited

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RX Processing Reminders

- GLP-1 medications – utilization management
  - Limited to 30-day supply/RX
  - Starter doses limited to an initial dispense, then titration needed
  - Review Reject reason carefully, many can be corrected without initiating PA

- Opioid RXs for opioid-naïve patients (*SUPPORT Act; CMS Opioid guidance*)
  - 1st fill limited to 7-day supply and <50 MME/day dosing
  - Fill will process without requiring PA if above parameters are met

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Drug Formulary Changes

MedStar Family Choice

DISTRICT OF COLUMBIA

MFC-DC Formulary Changes

- Effective January 1, 2025

Removals:	
• Trulicity (All strengths)* *Enrollees currently taking the medication with be grandfathered in. • Ajovy • Orenitram	

*See Prior Authorization and Step Therapy Table for clinical criteria. The **table is updated regularly.** Most current version available here: MedStarFamilyChoiceDC.com/providers/pharmacy

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DISTRICT OF COLUMBIA

MFC-DC Formulary Changes

- Effective January 1, 2025

- Additions: Exclusive Pen needles (Owen Mumford)

Brand Name	Manufacturer	Route	Effective Date	Comments
Pentips	Owen Mumford	Needle	1/1/2026	
Unifine Pentips	Owen Mumford	Needle	1/1/2026	
Unifine Pentips Plus	Owen Mumford	Needle	1/1/2026	**Built-in Remover**
Unifine Safe Control	Owen Mumford	Needle	1/1/2026	**Comes with a safety lock**

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MFC-DC Formulary Changes

- Effective January 1, 2026

  - **Products Covered**: Pentips, Unifine Pentips, Unifine Pentips Plus (remover), Unifine Safe Control (safety lock)
  - **Availability**: Universally available across pharmacies; all necessary sizes stocked
  - **Implementation Support**: Manufacturer rep will confirm pharmacy stocking and provide emergency supplies during rollout
  - **Prescriber Impact**: Minimal, most prescriptions simply state "pen needles"
  - **Pharmacy Flexibility**: Pharmacies may automatically substitute Owen Mumford needles, even if another brand is written
  - **System Updates**: Indices/identifiers will guide pharmacies to the preferred products

  ⋆This transition is expected to be seamless for prescribers, pharmacies, and Enrollees while improving consistency across the formulary.

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POS Beneficiary Notice Forms

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Beneficiaries Notice – Triplicate Form Request

REQUEST DATE: / /

REQUESTER OR CONTACT PERSON INFORMATION

REQUESTER'S OR CONTACT PERSON'S FULL NAME:

REQUESTER'S OR CONTACT PERSON'S EMAIL:

REQUESTER'S OR CONTACT PERSON'S PHONE NUMBER:

– –

PHARMACY PHYSICAL ADDRESS:

CITY: **STATE:** **ZIP:**

PHARMACY INFORMATION

PHARMACY NAME:

PHARMACY PHONE NUMBER: – – **PHARMACY FAX NUMBER:** – –

PHARMACY NPI #:

Beneficiaries Notice Requirements

- The Department of Health Care Finance (DHCF) is requiring the District Medicaid program's participating pharmacies to distribute individualized written notices to Medicaid beneficiaries whose prescription medication claim requests are denied after adjudication at the pharmacy point of sale. The notice explains the rights a beneficiary has when a prescription claim is denied by Medicaid, the responsibilities of the beneficiary, the responsibilities of the pharmacists, and provides a contact number for the District Medicaid pharmacy benefit manager (PBM) call center. A beneficiary who continues to believe the claim should be approved by Medicaid may request a Fair Hearing before an Administrative Law Judge.
- This applies to all beneficiaries who are served by DC Medicaid, including those enrolled in all DC Medicaid Managed Care Organizations as follows: Amerigroup DC, AmeriHealth Caritas DC, and MedStar Family Choice DC, and Health Services for Children with Special Needs (HSCSN).
- Additional information is available at Written Pharmacy Point of Service (POS) Notice. (URL: https://dhcf.dc.gov/node/1661466)

ACTION REQUIERED. PLEASE CHECK ALL THAT APPLY

1. **Form quantity requested:** ☐ 100 ☐ 200 ☐ 300 ☐ Other: _____
2. **Are you returning forms?** ☐ Yes ☐ No

If yes, how many forms are you returning? _____

ADDITIONAL INFORMATION

_____

_____

REQUESTOR'S SIGNATURE: _____

REQUESTOR'S PRINT NAME: _____ **DATE**_____

Send form to : DCMedicaidTriplicateForms@primetherapeutics.com
DC Medicaid PBM Call Center Phone: 1-800-273-4962

DHCF Secure Fax 202-722-5685
 Revision Date: 06/23/2025

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POS Beneficiary Notice Forms Reminder

- Pharmacy providers are responsible for distributing a POS Beneficiary Notice form to DC Medicaid Enrollees upon RX claim rejection.
    - Triplicate Form replenishment is available from: www.dc-pbm.com

- MFC-DC Pharmacy Staff is conducting random outreach to validate whether this form was provided to Enrollees. *You may be contacted by phone.*

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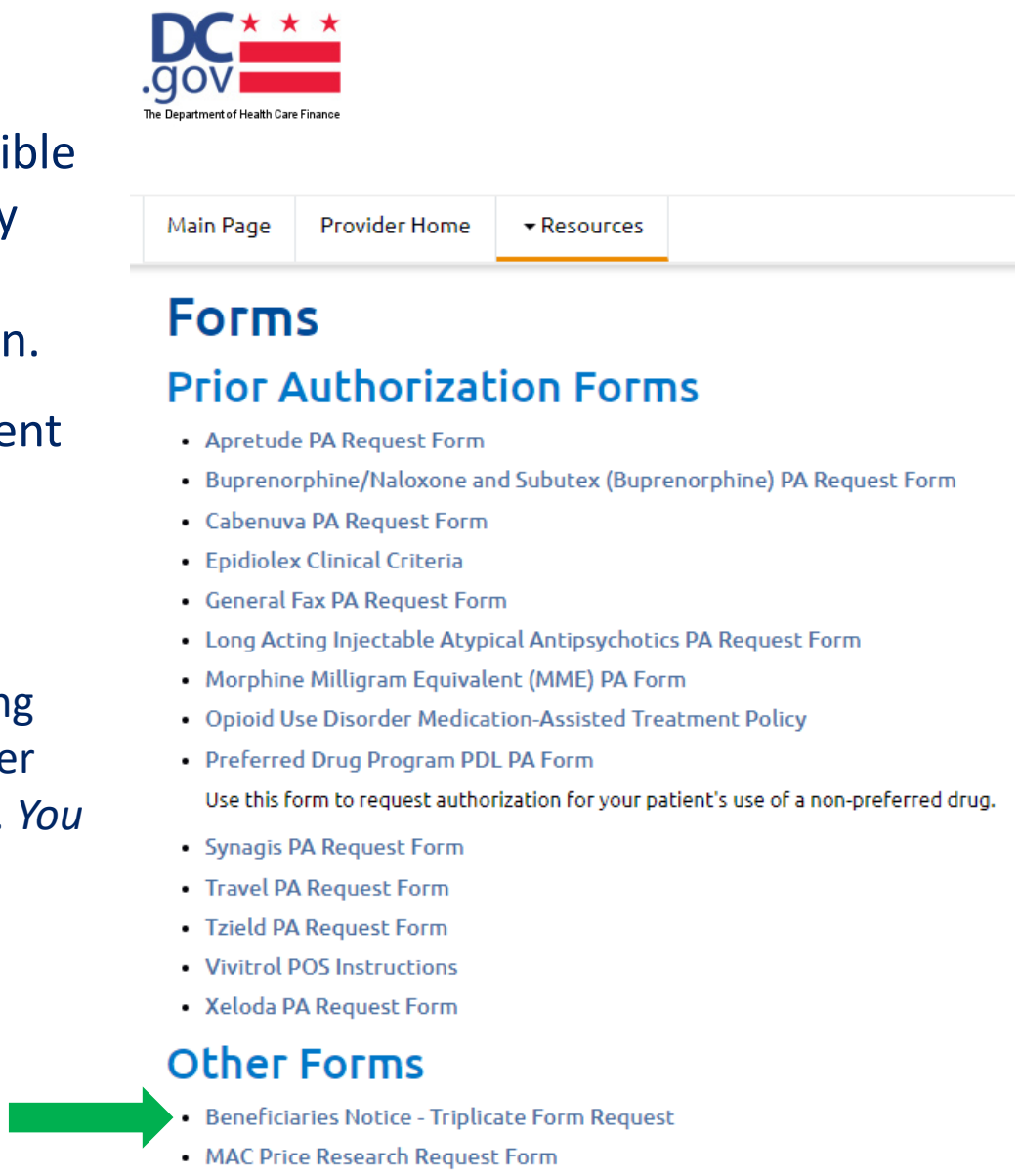

Provider Resources

MedStar Family Choice

DISTRICT OF COLUMBIA

Pharmacy Contact Information

Contact	Phone Number
MFC-DC Precertification (Prior Auth) Team • *For prior authorization during normal business hours* • *For calls received after 5:30pm*	(855) 798-4244 (855) 798-4244, prompt 2
CVS Caremark Pharmacy Help Desk • *For claims processing issues*	(800)364-6331
For issues not resolved using the above resources, contact the health plan pharmacist, Dr. Mina Tawfeik, PharmD	(240) 935-6218

MedStar Family Choice
DISTRICT OF COLUMBIA

CVSHealth

PBM: CVS CareMark
RX PCN: MCAIDADV
RX Bin: 004336
Rx Group: RX0610

MFC-District of Columbia Office Information

MedStar Family Choice – DC Office:

3007 Tilden Street NW POD 3N

Washington, DC 20008

(855) 798-4244

www.medstarfamilychoicedc.com

Hours of Operation: 8:00AM – 5:30PM (Monday – Friday)

MedStar Family Choice

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MedStar Family Choice

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Questions?

MedStar Family Choice

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DHCF Quarterly Pharmacy Forum- 4Q2025
December 16th & 17th, 2025

Leslie Addison, Manager Pharmacy Services

HSCSN

Agenda

- Pharmacy Update
- Drug Formulary Updates
- 7 Days Emergency Fill (7DEF)
- DAWs
- Pharmacy Service Help

HSCSN

Pharmacy Update

4th Quarter 2025

Pharmacy Update

New Pharmacy Insurance Billing & Card Update

Requirement: Federal Regulation 438.3 (7) - Managed Care Organizations (MCOs) are required to implement a Medicaid-specific Bank Identification Number (BIN) and Processor Control Number (PCN) on the member's prescription ID card.

Effective date for change: November 19, 2025

HSCSN Implementation completed: November 18, 2025

HSCSN

Drug Formulary Updates

4th Quarter 2025

Additions *January 1, 2026*

Drug	Preferred Non-Preferred	Brand Generic	Criteria
Austedo (deutetrabenazine) tab 6mg,9mg	Preferred	Brand	PA, SP, QL
Erzofri (paliperidone) inj 156/ml, 234/1.5ml, 351/2.25ml, 39/0.25ml, 78/0.5ml	Preferred	Brand	No PA
Esperoct (antihemophilic factor glycpegylate-exe) 1000u, 1500u, 2000u, 3000u, 4000u	Preferred	Brand	PA, SP
Methadone soln 5mg/5ml, 10mg/5ml	Preferred	Generic	ST, QL
Nexletol (bempedoic acid) tablet 180mg	Preferred	Brand	PA

HSCSN

Additions *January 1, 2026*

Drug	Preferred Non-Preferred	Brand Generic	Criteria
Nilotinib capsules 50mg, 150mg, 200mg	Preferred	Generic	PA, SP, QL
Rykindo (risperidone) inj 28mg, 37.5mg, 50mg	Preferred	Brand	No PA
Tagrisso (osimertinib) tablets 40mg, 80mg	Preferred	Brand	PA, SP, QL
Ticagrelor tab 60mg, 90mg	Preferred	Generic	No PA
Taltz (ixekizumab) inj 20/0.25ml, 40/0.5ml, 80mg/ml	Preferred	Brand	PA, SP, QL
Qvar Redihaler aero 40mcg, 80mcg	Preferred	Brand	QL

HSCSN

Deletions *January 1, 2026*

Drug	Brand/Generic
Entresto 6-6mg, 15-16mg capsules	Brand
Gel-One inj 30mg/3ml	Brand
Ingrezza 40mg, 60mg, 80mg, 40-80mg capsules	Brand
Jivi inj 500u, 1000u, 2000u, 3000u, 4000u	Brand
Norpace CR 100mg, 150mg capsules	Brand
Ojemda 100mg tablet , 25mg/ml suspension	Brand

HSCSN

Deletions *January 1, 2026*

Drug	Brand/Generic
Orenitram Month 1, 2, 3, 0.25mg, 0.125mg, 1mg, 2.5mg, 5mg tablets	Brand
Rextovy nasal spray	Brand
Segluromet 2.5-500, 2.5mg-1000, 7.5mg-500mg, 7.5mg-1000mg, 15mg tablets	Brand
Steglatro 5mg, 15mg tablet	Brand
Visco-3 inj	Brand
Xiidra 5% drops	Brand
Zelboraf 240mg tablets	Brand

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Pharmacy Drug Formulary Access

Search the Formulary »

Download the Formulary (Machine Readable) »

Download the Formulary [PDF] »

HSCSN website Pharmacy Benefits

https://hscsnhealthplan.org/enrollees/pharmacy-benefits

HSCSN

7 Days Emergency Fill (7DEF) Update

4th Quarter 2025

Handling Rejected Pharmacy Claims & 7 Days Emergency Fill

- When a claim rejects, there is a rejection messages with instructions.
- If **Prior Authorization (PA)** is required, use the override code for **7 Days Emergency Fill**.
- **Override code:** (USE PAMC 11112222333)
- Pharmacy Service does follow up process for identified claims.
- Outreach letters are sent to prescribers requesting PA submission to **CVS Caremark UM Team**.

For Assistance:

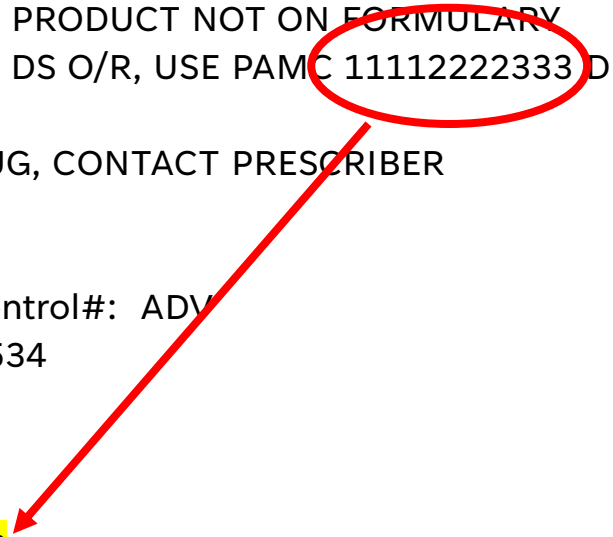
- **CVS Customer Care:** 1-866-885-4944
- **HSCSN Customer Care:** 202-467-2737
- **HSCSN Pharmacy Services:** 202-450-9678

HSCSN

Rejected 7 Days Emergency Fill (7DEF)

Rejected Claim Status

Reject Code - Description: 70 - NDC/Product/Service Not Covered
Reject Code - Description: MR - Product Not On Formulary
Description: PRODUCT NOT ON FORMULARY
Local Messages: FOR 7 DS O/R, USE PAMC 11112222333 DRUG REQUIRES PRIOR AUTHORIZATION
NON-FORMULARY DRUG, CONTACT PRESCRIBER
Claim Data
BIN: 004336
Submitted Processor Control#: ADV
Submitted Group: RX6534
COB Claim Indicator: 1
Paid Days: 7
Paid Quantity: 14.0
Override ID: ??????????



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Dispense As Written (DAWs)Updates

4th Quarter 2025

Dispense As Written (DAW) Code Restrictions and Exceptions

According to **DHCF Transmittal # 21-12,** prohibits the use of several DAW code.

DAW Code Restrictions

- **DAW 2** is prohibited.
- **Other DAWs** prohibited are DAW 3, DAW 5, DAW 6, DAW 7.

Exceptions

DAW 8- recommended for drug shortage claims.
DAW 9- recommended for Insurance Plan request brand drug use.

- Pharmacy Services will initiate outreach to pharmacies flagged for unacceptable DAW codes.

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Dispense As Written (DAW) Code Restrictions and Exceptions-cont'd

Acceptable DAW codes for Medication Assisted Treatment (MAT)

- DAW 0
- DAW 1
- DAW 4
- DAW 8

Acceptable DAW codes for ALL Other Prescribed Drugs

DAW 0

DAW 1

DAW 8

DAW 9

HSCSN

Point of Service (POS) Notice Update

4th Quarter 2025

Written Pharmacy Point of Service (POS) Notice

Remember.....

DHCF requires that the written notice to enrollees when a prescription is denied (**Transmittal 23-23**).

Random monthly audits are performed.

HSCSN

Pharmacy Service Help

4th Quarter 2025

HSCSN Pharmacy Services

Retail Pharmacy Services

- CVS/Caremark pharmacy network
- Limited to a 30-day supply of medication (max 34 days)
- No co-payments required

Specialty Pharmacy Service

CVS Specialty Pharmacy Fax (1-800-323-2445) or Phone (1-866-387-2573)

- High-cost medications for complex conditions
- Medication refill notifications are sent via email, text, or phone
- No co-payments required

HSCSN

Opioid Prior Authorization (PA) Request

- Physician must contact CVS Caremark Prior Authorization(PA) Customer Service when the prescription for **Opioid (CII)** is written for approval

- CVS Caremark PA Customer Service should be contacted if the following Prior Authorization (PA) are triggered:
  - -If more than 7 Days supply for short-acting opioids
  - -If for a long-acting opioids
  - -If for early refill thresholds
  - -If greater than 90 Morphine Milligram Equivalent (MME) daily
  - -If more than one opioid in 90 days

CVS Caremark PA Customer Service phone (1-844-449-8734)

HSCSN

General Prior Authorization (PA)

The process is completed through the CVS Caremark Utilization Team.

✓ **Phone**

Pharmacist/Prescriber

Contact CVS Caremark PA Department at 1-877-433-7643

✓ **Fax**

Prescriber (only)

- Fax PA form to CVS Caremark Team- 1-888-836-0730
- Fax PA form is located on the HSCSN website
- CVS Caremark will accept fax requests 24 hours a day

✓ *e***PA**

Pharmacist/Prescriber

CVS Cover My Meds

- https://www.covermymeds.health/prior-authorization-forms/caremark

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HSCSN Pharmacy Services

Leslie Addison, Pharmacist
Manager Pharmacy Services
Email: laddison@hschealth.org
Cell: 202-450-9678

Thank you

Questions/Comments

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Achievement Badges

HSCSN

For more information visit www.hscsnhealthplan.org.
For reasonable accommodations please call (202) 467-2737.

If you do not speak and/or read English, please call 202-467-2737 between 7:00 a.m. and 5:30 p.m. A representative will assist you. **English.**

Si no habla o lee inglés, llame al 202-467-2737 entre las 7:00 a.m. y las 5:30 p.m. Un representante se complacerá en asistirle. **Spanish.**

የእንግሊዝኛ ቋንቋ መናገርና ማንበብ የማይችሉ ከሆነ ከጧቱ 7:00 ሰዓት እስከ ቀኑ 5:30 ባለው ጊዜ በስልክ ቁጥር 202-467-2737 በመደወል እርዳታ ማግኘት ይችላሉ። **Amharic.**

Nếu bạn không nói và/hoặc đọc tiếng Anh, xin gọi 202-467-2737 từ 7 giờ 00 sáng đến 5 giờ 30 chiều. Sẽ có người đại diện giúp bạn. **Vietnamese.**

如果您不能講和/或不能閱讀英語，請在上午 7:00 到下午 5:30 之間給 (202) 467-2737 打電話，我們會有代表幫助您。**Traditional Chinese.**

영어로 대화를 못하시거나 영어를 읽지 못하시는 경우, 오전 7시 00분에서 오후 5시 30분 사이에 (202) 467-2737번으로 전화해 주시기 바랍니다. 담당 직원이 도와드립니다. **Korean.**

Si vous ne parlez pas ou lisez l'anglais, s'il vous plaît appeller 202-467-2737 entre 7:00 du matin et 5:30 du soir. Un représentant vous aidera. **French.**

DHCF | WE ARE WASHINGTON DC GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR

This program is brought to you by the Government of the District of Columbia Department of Health Care Finance.

HSCSN complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

HSCSN

Pharmacy Provider Forum

Tracey Davis, PharmD

December 2025

AmeriHealth Caritas
District of Columbia

Delivering the Next
Generation
of Health Care

Healthy DC

We will have several thousand of our enrollees transition in January 2026 to a different health plan. It is still a part of the AmeriHealth brand and it will be on the exchange platform.

AmeriHealth Caritas
District of Columbia

November 2025 P&T changes

AmeriHealth Caritas District of Columbia

The following products will be **added** to the formulary on 12/15/25:

- Penmenvy IM age limit required
- Orquidea Oral Tablet 0.35 MG
- Omnipod 5 Libre2Plus G6 Intro Kit (Gen 5) PA / QL needed
- Bosentan Oral Tablet Soluble 32 MG PA required
- Dexcom G7 15 Day Sensor PA / Step and QL needed
- Zurnai Injection Solution Auto-injector 1.5 MG/0.5ML

Additional additions

AmeriHealth Caritas District of Columbia

- Eliquis Oral Capsule Sprinkle 0.15 MG
- Eliquis (2 MG Pack) Oral Tablet Soluble 4 x 0.5 MG, Oral Tablet Soluble 0.5 MG, Oral Tablet Soluble 3 x 0.5 MG
- Otulfi Subcutaneous Solution 45 MG/0.5ML
- Avtozma Intravenous Solution 80 MG/4ML, 200 MG/10ML, 400 MG/20ML
- Injectafer Intravenous Solution 1000 MG/20ML
- Otezla/Otezla XR Initiation Pk Oral Tablet Therapy Pack 10&20&30&(ER)75 MG, Oral Tablet Extended Release 24 Hour 75 MG

Additional additions

AmeriHealth Caritas
District of Columbia

- Tyruko Intravenous Concentrate 300 MG/15ML PA required
- Doptelet Sprinkle Oral Capsule Sprinkle 10 MG PA required
- Repatha (evolocumab) new quantity limit requirement

Formulary deletions

AmeriHealth Caritas District of Columbia

The following products will be **deleted** to the formulary on 12/15/25:

- Eszopiclone Oral Tablet 1 MG, 2 MG, 3 MG
- Zolpidem Tartrate ER Oral Tablet Extended Release 12.5 MG, 6.25 MG
- Ambien CR Oral Tablet Extended Release 12.5 MG, 6.25 MG

Benefit Details

AmeriHealth Caritas
District of Columbia

90 Days supply

Hold over supply (5 days)

OTC (extensive benefit)

DTM (available through PBM and other pharmacies)

HIV (DTM done by HIV specialist)

Denials

Contact information

AmeriHealth Caritas DC Pharmacy Services

888-602-3741

8:00am-8:00pm Monday-Friday

9:00am-1:00pm Saturday

Pharmacy Director – Tracey Davis, PharmD

202-780-5816

tdavis4@amerihealthcaritasdc.com

AmeriHealth Caritas™

District of Columbia

Quarterly Pharmacy Provider Forum

Wellpoint District of Columbia

December 17-18, 2025

Wellpoint
District of Columbia

Agenda

- Upcoming Formulary Changes
- Network Updates
- Beneficiary Notice Forms
- Pharmacy Provider Resources

Key Formulary Changes

EFFECTIVE FOR ALL PATIENTS ON FEBRURAY 1, 2026		
Therapeutic class	**Drug**	**Revised status**
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES*	DOCETAXEL INJECTION FASLODEX INJECTION SYLVANT INJECTION ELITEK INJECTION VISTOGARD PAK BORUZU INJECTION BORTEZOMIB INJECTION VELCADE INJECTION AZACITIDINE INJECTION VIDAZA INJECTION	COVERED
CARDIOVASCULAR AGENTS – MISCELLANEOUS*	SACUBITRIL-VALSARTAN 24-26MG TABLET SACUBITRIL-VALSARTAN 49-51MG TABLET SACUBITRIL-VALSARTAN 97-103MG TABLET (GENERIC ENTRESTO)	PREFRRED
VITAMINS*	VITAMIN D2 400 UNIT TABLET VITAMIN D2 2000 UNIT CAPSULE/TABLET VITAMIN D 50000 UNIT CAPSULE	PREFRRED

Key Utilization Management Changes

	EFFECTIVE FOR ALL PATIENTS ON FEBRURAY 1, 2026	
Therapeutic class	**Drug**	**Revised status**
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	ARYNTA 10MG/ML ORAL SOLUTION	ADD PA AND QL 7 ML PER DAY
ANALGESIC COMBINATIONS	BUTALBITAL-ACETAMINOPHEN-CAFFEINE 50 MG-325MG-40 MG/15ML ORAL SOLUTION	ADD PA AND QL 90 ML PER DAY
ANTIDEMENTIA AGENTS	LEQEMBI IQLK 360MG/1.8ML AUTOINJECTOR	ADD PA AND QL 4 AUTOINJECTORS PER 28 DAYS
ANTIDIABETICS	ACTOS 15MG, ACTOS 45MG, ACTOS 30MG TABLETS	REMOVE STEP THERAPY
ANTIHISTAMINES	CARBINOXAMINE MALEATE 4MG TABLET	ADD QL 6 TABLETS PER DAY
ANTIHISTAMINES	CARBZAH (CARBINOXAMINE MALEATE) 4MG/ 5ML	ADD QL 20 MLS PER DAY
ANTIHYPERTENSIVES**	WIDAPLIK 10MG/1.25MG/ 0.625MG TABLET WIDAPLIK 20MG/2.5MG/1.25MG TABLET WIDAPLIK 40 MG/5MG/2.5MG TABLET	ADD QL 1 TABLET PER DAY
ANTIHYPERTENSIVES**	VOSTALLY 1 MG/ML ORAL SOLUTION	ADD PA AND QL 20 ML PER DAY
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	LEUCOVORIN 5MG, 10MG,15MG AND 20MG TABLETS	ADD QL 2 TABLETS PER DAY
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES**	ZEGFROVY 150MG TABLET ZEGFROVY 200 MG TABLET	ADD PA AND QL 1 TABLET PER DAY
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	IBTROZI 200MG CAPSULE	ADD PA AND QL 3 TABLETS PER DAY
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	LYNOZYFIC INJECTION	ADD PA
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	LUMAKRAS 240MG TABLET	ADD QL 4 TABLETS PER DAY
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	BRUKINSA 160MG TABLET	ADD QL 2 TABLETS PER DAY

Key Utilization Management Changes Cont.

	EFFECTIVE FOR ALL PATIENTS ON FEBRURAY 1, 2026	
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	ZUSDURI 80MG INJECTION	ADD PA
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES**	CAMCEVI ETM 21MG PRE-FILLED SYRINGE	ADD PA AND QL 1 SYRINGE PER 12 WEEKS
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES**	VABRINTY 7.5MG KIT	ADD QL 1 KIT PER 4 WEEKS
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	VABRINTY 30MG KIT	ADD QL 1 KIT PER 16 WEEKS
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	VABRINTY 22.5MG KIT	ADD PA AND QL 1 KIT PER 12 WEEKS
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	VABRINTY 45MG KIT	ADD PA AND QL 1 KIT PER 24 WEEKS (6 MONTHS)
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	MODEYSO 125MG CAPSULES	ADD PA AND QL 20 CAPSULES PER 28 DAYS
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	HERNEXEOS 60MG TABLET	ADD PA AND QL 3 TABLETS PER DAY
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	ZEJULA 100MG TABLET	UPDATE QL ~~3~~ 1 TABLETS OR CAPSULES PER DAY
ANTI-OBESITY AGENTS	WEGOVY 0.25MG PEN WEGOVY 0.5 MG PEN WEGOVY 1 MG PEN WEGOVY 1.7 MG PEN WEGOVY 2.4 MG PEN	UPDATE QL ~~1 PEN PER WEEK~~ 4 PENS PER 28 DAYS
ANTIVIRALS	PAXLOVID 300 MG/100 MG + 150 MG/100 MG	ADD QL 1 DOSE PACK PER FILL; 1 FILL PER 90 DAYS
BETA BLOCKERS	LOPRESSOR ORAL SOLUTION	ADD PA
BONE DENSITY REGULATORS	RISEDRONATE 30MG	UPDATE QL 1 TABLET PER DAY, ~~MAXIMUM OF 16 TREATMENT WEEKS~~
BONE DENSITY REGULATORS	FORTEO 600MCG/2.4 ML 560 MG/2.24 ML INJECTION BONSITY 620MCG/ 2.48 ML 560 MG/2.24 ML INJECTION TERIPARATIDE 560 MG/2.24 ML INJECTION	ADD QL 1 PEN PER 28 DAYS

Key Utilization Management Changes Cont.

	EFFECTIVE FOR ALL PATIENTS ON FEBRURAY 1, 2026	
CALCIUM CHANNEL BLOCKERS**	SDAMLO 2.5MG SDAMLO 5MG SDAMLO 10MG ORAL SOLUTION	ADD PA AND QL 1 SINGLE-DOSE BOTTLE PER DAY
CARDIOVASCULAR AGENTS - MISC.	CORLANOR 5MG CORLANOR 7.5MG	REMOVE QL 2 TABLETS PER DAY
CARDIOVASCULAR AGENTS - MISC.	CORLANOR 5MG/5ML ORAL SOLUTION AMPULE	REMOVE QL 4 AMPULES PER DAY (4 CARTONS PER 28 DAYS)
CARDIOVASCULAR AGENTS - MISC.	YUTREPIA 26.5MCG CAPSULE YUTREPIA 53MCG CAPSULE	ADD PA AND QL 5 CAPSULES PER DAY
CARDIOVASCULAR AGENTS - MISC.	YUTREPIA 79.5MCG CAPSULE	ADD PA AND QL 10 CAPSULES PER DAY
CARDIOVASCULAR AGENTS - MISC.	YUTREPIA 106MCG CAPSULE	ADD PA AND QL 8 CAPSULES PER DAY
CARDIOVASCULAR AGENTS - MISC.	UPTRAVI 200MCG STARTER BOTTLE	ADD QL 1 PACK, ONE TIME FILL
CARDIOVASCULAR AGENTS - MISC.	SACUBITRIL-VALSARTAN 24-26MG TABLET SACUBITRIL-VALSARTAN 49-51MG TABLET SACUBITRIL-VALSARTAN 97-103MG TABLET (GENERIC ENTRESTO)	REMOVE PA
CENTRAL MUSCLE RELAXANTS	TONMYA 2.8 MG SUBLINGUAL TABLET	ADD PA AND QL 2 SUBLINGUAL TABLETS PER DAY
CENTRAL MUSCLE RELAXANTS**	ATMEKSI 750MG/5 ML ORAL SUSPENSION	ADD ST AND QL 30 ML PER DAY
CENTRAL MUSCLE RELAXANTS	METAXALONE 640MG	ADD ST AND QL 4 TABLETS PER DAY
CORTICOSTEROIDS	KHINDIVI 1MG/ML ORAL SOLUTION	ADD PA
CORTICOSTEROIDS - TOPICAL	HYDROCORTISONE ACETATE 2.5% CREAM (MICORT HC)	ADD ST AND QL 30 GRAMS PER 30 DAYS
COUGH/COLD/ALLERGY	CODITUSSIN DAC (PSEUDOEPHEDRINE-GUAIFENESIN WITH CODEINE)	ADD QL 200 ML PER 5 DAYS; 2 FILLS PER 30 DAYS
DENTAL PRODUCTS	FRAICHE 5000 DENTAL GEL	ADD QL 100 G/ML PER 30 DAYS
DIABETIC SUPPLIES	MODD1 PATIENT WELCOME KIT AND SUPPLY KIT	ADD PA AND QL WELCOME KIT (1 KIT PER 90 DAYS); SUPPLY KIT (1 KIT PER 30 DAYS)
DIABETIC SUPPLIES	TWIIST INSULIN PUMP STARTER KIT	UPDATE QL 1 KIT ~~PER 30 DAYS~~, ONE TIME FILL
ECZEMA AGENTS	ANZUPGO 2% CREAM	ADD PA AND QL 60 GRAMS PER 30 DAYS
ENDOCRINE AND METABOLIC AGENTS - MISC.	KERENDIA 40 MG TABLET	ADD QL 1 TABLET PER DAY

Key Utilization Management Changes Cont.

	EFFECTIVE FOR ALL PATIENTS ON FEBRURAY 1, 2026	
GASTROINTESTINAL AGENTS - MISC.	STARJEMZA 130 MG/26 ML (5 MG/ML) VIAL	ADD PA AND DOSING LIMIT
GASTROINTESTINAL AGENTS - MISC.	STARJEMZA 45 MG/0.5 ML VIAL STARJEMZA 45 MG/0.5 ML SINGLE-USE PREFILLED SYRINGE STARJEMZA 90 MG/1 ML SINGLE-USE PREFILLED SYRINGE	ADDPA AND QL 1 VIAL/SYRINGE PER 84 DAYS (12 WEEKS)
GENITOURINARY AGENTS - MISCELLANEOUS	VENXXIVA 100MG TABLET	ADD PA AND QL 10 TABLETS PER DAY
GENITOURINARY AGENTS - MISCELLANEOUS	VENXXIVA 300MG TABLET	ADD PA AND QL 3 TABLETS PER DAY
GROWTH HORMONES	SKYTROFA 0.7MG CARTRIDGE SKYTROFA 1.4MG CARTRIDGE SKYTROFA 1.8MG CARTRIDGE SKYTROFA 2.1MG CARTRIDGE SKYTROFA 2.5MG CARTRIDGE	ADD QL 4 CARTRIDGES PER 28 DAYS
HEMATOLOGICAL AGENTS - MISC.	EKTERLY 300MG TABLETS	ADD PA AND QL 24 TABLETS (6 CARTONS) PER 30 DAYS
HEMATOLOGICAL AGENTS - MISC.	ANDEMBRY 200MG/1.2 ML PREFILLED AUTO-INJECTOR/PREFILLED SYRINGE	ADD PA AND QL 1 PREFILLED AUTOINJECTOR/SYRINGE PER 28 DAYS
HEMATOLOGICAL AGENTS - MISC.	DAWNZERA 80MG/0.8 ML AUTOINJECTOR	ADD QL 1 AUTOINJECTOR PER 28 DAYS
HEMATOPOIETIC GROWTH FACTORS	DOPTELET SPRINKLE 10 MG CAPSULE	ADD PA AND QL 2 CAPSULES PER DAY
INFLUENZA AGENTS**	XOFLUZA 30MG ORAL SUSPENSION PACKET	ADD QL 1 PACKET PER FILL; 1 FILL PER 90 DAYS
INFLUENZA AGENTS**	XOFLUZA 40MG ORAL SUSPENSION PACKET	ADD QL 2 PACKETS PER FILL; 1 FILL PER 90 DAYS
METABOLIC MODIFIERS	ELFABRIO 5MG/2.5 ML	ADD DOSING LIMIT
METABOLIC MODIFIERS	HARLIKU 2MG TABLET	ADD PA AND QL 1 TABLET PER DAY
METABOLIC MODIFIERS	SEPHIENCE ORAL POWDER	ADD PA

Key Utilization Management Changes Cont.

	EFFECTIVE FOR ALL PATIENTS ON FEBRURAY 1, 2026	
NASAL ANTIALLERGY	ALLERGY NASAL SPRAY 0.15% (AZELASTINE) (205.5 MCG/SPRAY) (30 ML/200 SPRAYS)	ADD QL 30 ML PER 25 DAYS
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	VYSCOXA 10MG/ML ORAL SUSPENSION	ADD PA AND QL 40 ML PER DAY
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	IBUPROFEN 300MG TABLET	ADD ST AND QL 4 TABLETS PER DAY
OPHTHALMIC AGENTS	TRYPTYR 0.003% OPHTHALMIC SOLUTION	ADD PA AND QL 2 VIALS PER DAY
OPHTHALMIC AGENTS	VIZZ 1.44% OPHTHALMIC SOLUTION	ADD PA AND QL 1 VIAL PER DAY
OPHTHALMIC AGENTS	LASTACAFT 0.25% OPHTHALMIC SOLUTION (OTC)	UPDATE QL ~~3~~ 5 ML PER 30 DAYS
OPHTHALMIC AGENTS	OLOPATADINE 0.2% OPHTHALMIC SOLUTION (OTC)	UPDATE QL ~~2.5~~ 3.5 ML PER 30 DAYS
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS	OTEZLA/OTEZLA XR 28-DAY STARTER PACK	ADD PA AND QL 1 PACK (28 DAY SUPPLY, ONE TIME FILL)
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS	OTEZLA XR 75MG TABLET	ADD PA AND QL 1 TABLET PER DAY
PRENATAL VITAMINS	CENTRUM PRENATAL MULTIVITAMIN GUMMIES	ADD QL 2 GUMMIES PER DAY
PRENATAL VITAMINS	MATERVIA CAPSULE	ADD QL 2 CAPSULES PER DAY
PROGESTINS	PROMETRIUM 100 MG CAPSULE PROMETRIUM 200 MG CAPSULE	REMOVE QL 2 CAPSULES PER DAY
PROGESTINS	PROVERA 2.5MG TABLET PROVERA 5MG TABLET PROVERA 10 MG TABLET	REMOVE QL 1 TABLET PER DAY
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	AUSTEDO XR 6-24 12-30MG TITRATION KIT	ADD QL 1 KIT PER FILL, ONE TIME FILL
RESPIRATORY AGENTS - MISC.	BRINSUPRI 10MG TABLET BRINSUPRI 25MG TABLET	ADD PA AND QL 1 TABLET PER DAY
RESPIRATORY SYNCYTIAL VIRUS (RSV) AGENTS	VIRAZOLE (RIBAVIRIN INHALATION)	REMOVE PA

Pharmacy Network Updates

Pharmacy Network Search

Network is searchable on provider and enrollee sites and on the CarelonRx mobile app and the Sydney Health mobile app

Online searchable tool: https://findcare.wellpoint.com/search-providers

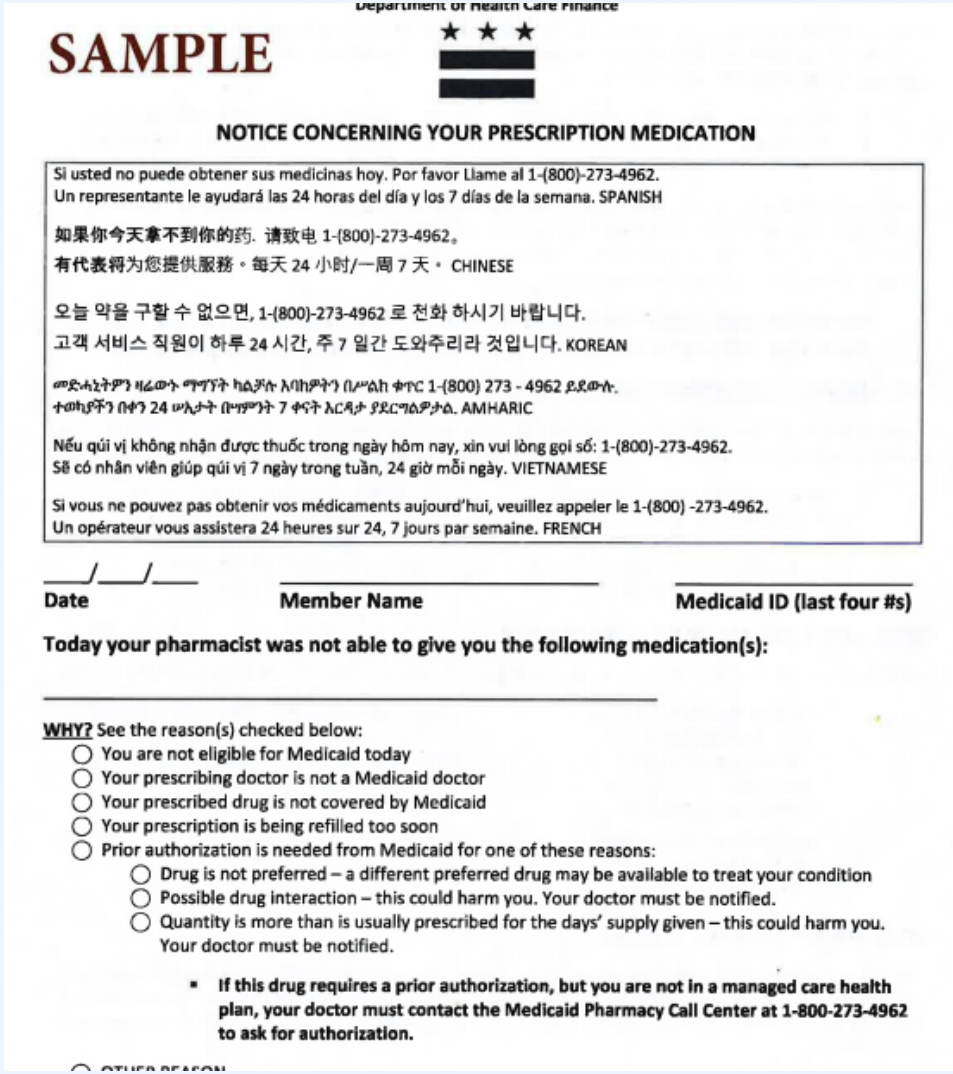
Reminder: Beneficiary Notice Forms

Reminder: DC Medicaid participating pharmacies are required to distribute individualized written notice (Triplicate Forms) to Medicaid beneficiaries when a prescription claim is denied at POS.

To request Triplicate Form replenishment, visit:

https://www.dc-pbm.com/provider/forms

Note: PBM staff conduct random outreach calls to Wellpoint DC network pharmacies to confirm distribution of the Triplicate Forms.



Department of Health Care Finance

SAMPLE

NOTICE CONCERNING YOUR PRESCRIPTION MEDICATION

Si usted no puede obtener sus medicinas hoy. Por favor Llame al 1-(800)-273-4962.
Un representante le ayudará las 24 horas del día y los 7 días de la semana. SPANISH

如果你今天拿不到你的药. 请致电 1-(800)-273-4962。
有代表将为您提供服务。每天 24 小时/一周 7 天。 CHINESE

오늘 약을 구할 수 없으면, 1-(800)-273-4962 로 전화 하시기 바랍니다.
고객 서비스 직원이 하루 24 시간, 주 7 일간 도와주리라 것입니다. KOREAN

መድሓኒትዎን ዛሬውኑ ማግኘት ካልቻሉ እባክዎትን በሥልክ ቁጥር 1-(800) 273 - 4962 ይደውሉ.
ተወካያችን በቀን 24 ሠዓታት በሣምንት 7 ቀናት እርዳታ ያደርግልዎታል. AMHARIC

Nếu qúi vị không nhận được thuốc trong ngày hôm nay, xin vui lòng gọi số: 1-(800)-273-4962.
Sẽ có nhân viên giúp qúi vị 7 ngày trong tuần, 24 giờ mỗi ngày. VIETNAMESE

Si vous ne pouvez pas obtenir vos médicaments aujourd'hui, veuillez appeler le 1-(800) -273-4962.
Un opérateur vous assistera 24 heures sur 24, 7 jours par semaine. FRENCH

___/___/___ Date | Member Name | Medicaid ID (last four #s)

Today your pharmacist was not able to give you the following medication(s):

WHY? See the reason(s) checked below:

- ◯ You are not eligible for Medicaid today
- ◯ Your prescribing doctor is not a Medicaid doctor
- ◯ Your prescribed drug is not covered by Medicaid
- ◯ Your prescription is being refilled too soon
- ◯ Prior authorization is needed from Medicaid for one of these reasons:
  - ◯ Drug is not preferred – a different preferred drug may be available to treat your condition
  - ◯ Possible drug interaction – this could harm you. Your doctor must be notified.
  - ◯ Quantity is more than is usually prescribed for the days' supply given – this could harm you. Your doctor must be notified.
    - **If this drug requires a prior authorization, but you are not in a managed care health plan, your doctor must contact the Medicaid Pharmacy Call Center at 1-800-273-4962 to ask for authorization.**

◯ OTHER REASON

Pharmacy Claims Processing Information

DC Healthy Families Medicaid

RxBIN: 020107

RxPCN: FC

RxGroup: RX8479

Pharmacy Contact Information

Pharmacy Benefit Manager: CarelonRx

Pharmacy Enrollee Services

Phone Number: **1-833-214-3604**

Available 24/7/365

Enrollee medication inquiries

Other health insurance (OHI) reviews

Out of area override requests (traveling)

Mail order inquires

Specialty pharmacy delivery inquires

Pharmacy Help Desk:

Phone Number: **1-833-214-3604**

Available 24/7/365

Pharmacy claims adjudication issues

Wellpoint DC

Enrollee Services: **1-800-600-4441**

Provider Services: **1-800-454-3730**

Thank you!

Questions?

Insert appropriate disclosure from the Legal Disclosure Database

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