Quarterly Pharmacy Provider Forum

Department of Health Care Finance

Tuesday, March 17th 1-3pm

Wednesday, March 18th 11-1pm

AGENDA

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

DHCF UPDATES

New MMIS Portal

- Reporting tool for Suspected Fraud, Waste and Abuse
- HIV Antiretroviral Coverage Reminder
- Beneficiary Claims Denial Notification Reminder

Fee for Service MTM Program

Gainwell Technologies is the new Fiscal Agent for DC Medicaid Provider Payments

MMIS new portal https://medicaid.dc.gov/

Register for a portal account today

Please direct questions about portal registration and training to the Contact Center at (866) 752-9233, available Monday - Friday, 8 a.m. - 5 p.m. EST.

For technical assistance, providers may contact the DC Medicaid helpdesk at: dcedi@gainwelltechnologies.com.

Reporting Suspected Fraud Waste & Abuse (FWA)

How can I **report** suspected fraud, waste, and abuse (**FWA**)

Fillable form i-Sight | New Case

When submitting an FWA message or report, include as much detail as possible, such as:

- Name and contact information of the suspect/entity (if known).
- Nature of the suspected FWA (e.g., billing, scripting).
- Patient/member information involved.
- Dates of service.

Contact information

- Phone: (202) 698-2000
- Fraud Hotline: 1-877-632-2873

Pharmacy Providers Enrollment Reminder

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

Provider Enrollment Inquiries

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

HIV Antiretroviral Medication Coverage Reminders

HIV Treatment, PrEP and PEP medication coverage is "Carved-out" pharmacy benefit from the DC Medicaid managed care plans

For MCP members: Bill HIV antiretroviral claims for treatment, PrEP and PEP to FFS through Prime Therapeutics using

BIN 0184407
PCN DCMC018407

For Alliance ICP Program Enrollees:

Treatment of HIV for Ages 18 years old and greater – refer to DC Health Pharmacy Benefit Program(formerly ADAP) for coverage and enrollment questions

Claims with Diagnosis of PREP or PEP – Bill to FFS

Pharmacy Audit Process

Ensures compliance with Medicaid provider agreement.

Auditors perform On-site and desk audits Implemented October 1, 2024

Goal

- Provide continuing education and enhanced support to Medicaid enrolled pharmacies
- Reinforce pharmacy responsibility on use of triplicate forms for denied claims for a beneficiary

FY26Q1 Onsite Audit Findings

Audited Pharmacy Status	# NPI
FAIL	11
Pharmacy did not have any signage posted.	6
Pharmacy did not have second signage posted.	2
Pharmacy did not have the first signage posted.	3
PASS	17
Grand Total	**28**

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

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

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 በሥልክ ቁጥር 1-(800) 273 - 4962 ይደውሉ.
ተወካያቸን በቀን 24 ሠዓታት በሣምንት 7 ቀናት አርዲታ 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**

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.

Beneficiary Triplicate Notice Form Request links

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 should be completed, saved and then send copy to email - DCMedicaidTriplicateForms@primetherapeutics.com

DHCF FFS MTM Program

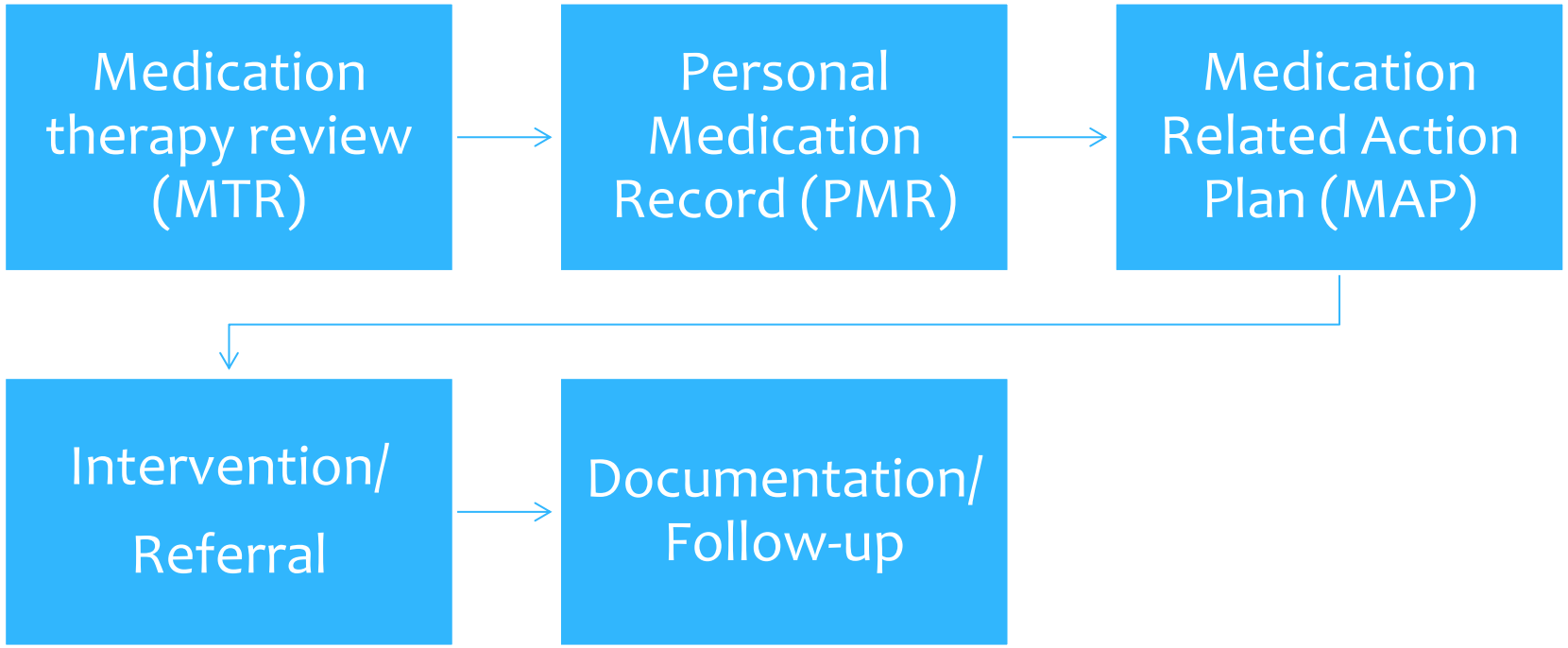
Dr. Tayiana J. Reed
Pharmacist, DHCF
Office of the Chief Medical Officer

What is Medication Therapy Management (MTM)?

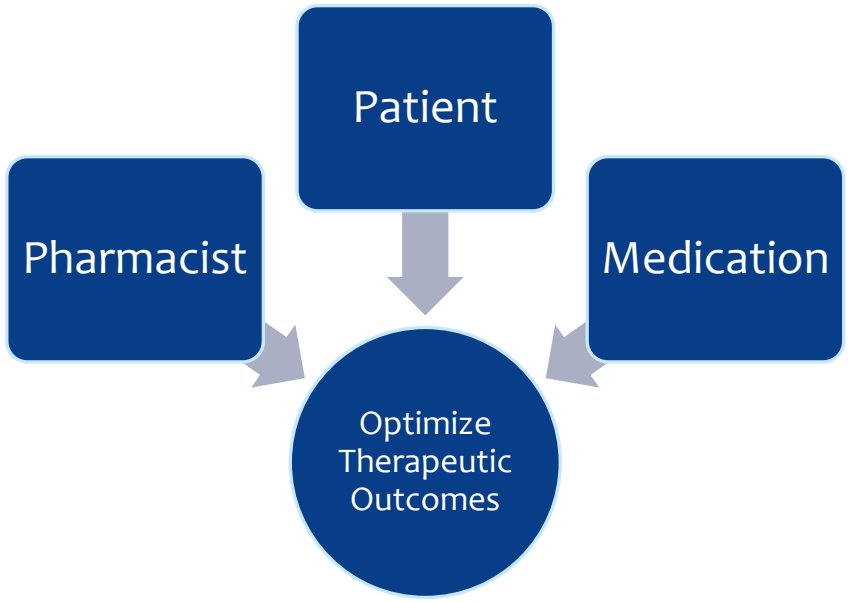
Medication therapy management (MTM) services focus on identifying, preventing, and solving drug-related problems to optimize therapeutic outcomes for individual patients.

MTM may be independent of OBRA-90 counseling statue and involves a thorough review of the patient's medications, including medication use history, medical history, and adherence to therapy to identify and resolve drug therapy problems with the patient and/or in collaboration with other health care providers.

MTM Core Elements



Goal of the FFS MTM Program



MTM Service Initiatives

Treatment Plan	•Development plan •Document care delivered by pharmacist to primary providers
Comprehensive Reviews	•Medication •Immunization •Prevent medication errors
Monitoring & Evaluation	•Medication response •Safety & Efficacy
Coordination	•Integrating MTM services with other health care services provided to the beneficiary
Education	•Support services •Medication adherence to regimens •Appropriate use of medications

MTM Beneficiary Eligibility

Must be an outpatient

3 or more qualifying health conditions

Non-adherent

Must be prescribed 10 + meds per month

Must be eligible for DHCF Lock in

MTM Categories Served

- FFS Lock-in Beneficiaries
- Individual beneficiaries
- My Health GPS enrollees

MTM Eligibility Exclusion

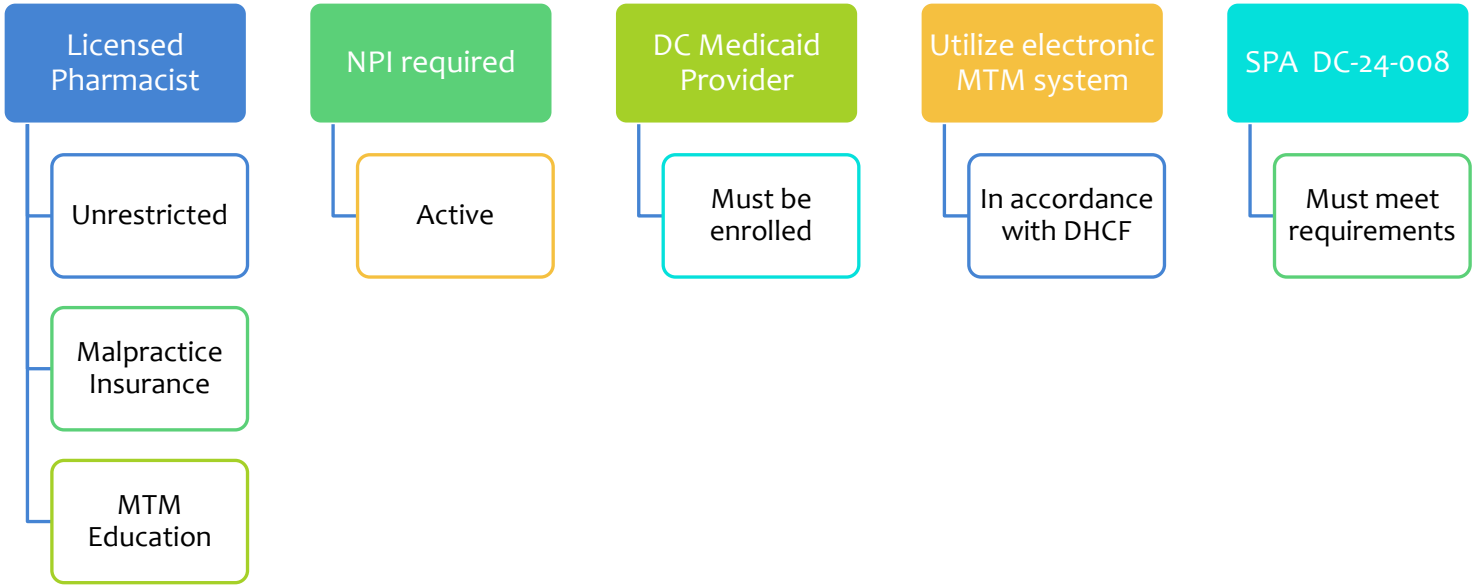
Medicare Part D Beneficiaries

Includes dual eligible

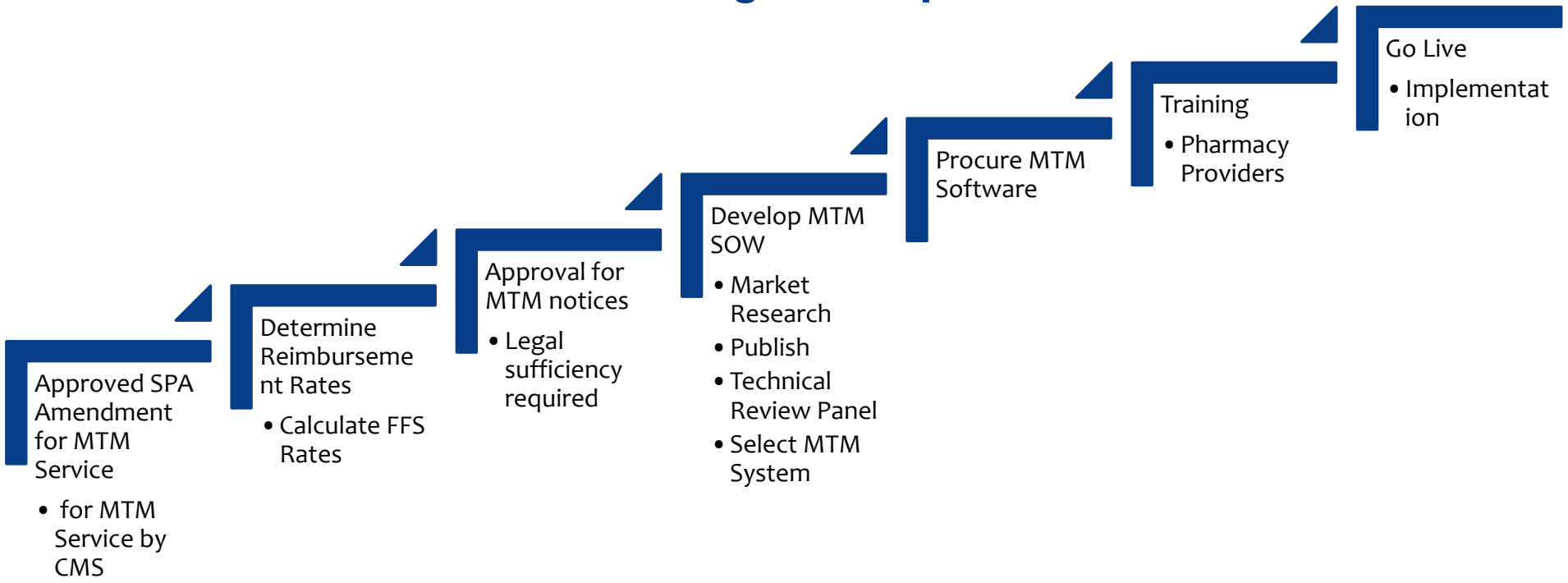
Health Home Program Beneficiaries

Chronic care program contractors currently providing MTM services

MTM Pharmacy Provider Eligibility



DHCF FFS MTM Program Implementation



Contact Information

Fee for Service Medicaid

Fee for Service Web Portal

Home | DC Pharmacy Programs

Access to FFS PDL (Preferred Drug List), Prior authorization forms, Provider Manual

Diabetic Supply List

DCRx_Diabetic_Supply_Program_Listing.pdf

Preferred Drug List DCRx_PDL_listing.pdf

Alliance ICP Program generic only formulary with exclusions

DCRx_Limited_Alliance_Formulary.pdf

District Alliance PA Request Form

DHCF Contact Information

Charlene Fairfax, BS Pharm, RPh
Senior Pharmacist
Charlene.fairfax@dc.gov or 202-442-9076

Gidey Amare, PharmD, MS, RPh
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

Prime Therapeutics Contact Information

Prime Therapeutics DC Pharmacy Program fax #

1-866-535-7622

Prime Therapeutics DC Clinical call center (24/7/365)

800-273-4962

Prime Therapeutics Pharmacy Technical Support

800-272-9679

DC-FFSProviderRelations@primetherapeutics.com

MCP UPDATES

OPEN DISCUSSION

MedStar Family Choice

DISTRICT OF COLUMBIA

It's how we treat people.

March 17th & 18th , 2026

Pharmacy Provider Forum

District of Columbia Healthy Families

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

Pharmacy Team Members

Health Plan Pharmacist, MFC DC

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DISTRICT OF COLUMBIA

Agenda

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

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DISTRICT OF COLUMBIA

Prior Authorizations

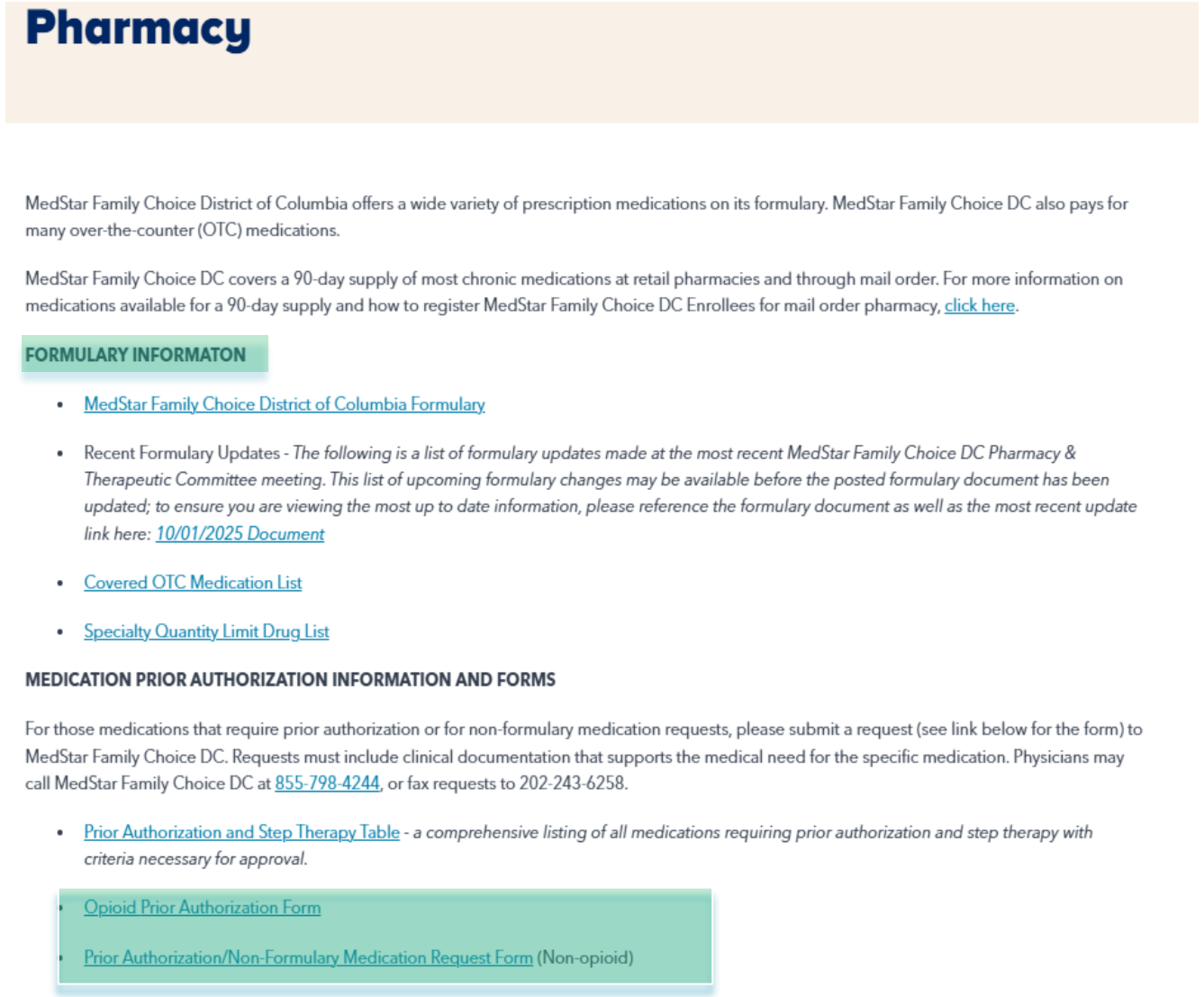
MedStar Family Choice

DISTRICT OF COLUMBIA

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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DISTRICT OF COLUMBIA

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**

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DISTRICT OF COLUMBIA

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
  - Ultra-long-acting Degludec- BRAND Tresiba
  - 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**

Ozempic: the 0.25/0.5 mg strength combines the starter-dose and titration-dose and is limited to two, 28-day dispenses and then must be dose escalated to 1 mg per week dose **UNLESS** A1c ≤ 7.0 or TIR ≥ 65%.

Mounjaro 2.5 mg is a starter dose and is limited to one, 28-day supply and then must be dose escalated to 5 mg per week dose **UNLESS** A1c ≤ 7.0 or TIR ≥ 65% on 2.5 mg dose.

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Drug Formulary Changes

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Formulation Addition

- **Wegovy**
  - To cover treatment of non-cirrhotic metabolic dysfunction associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH), with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) in adults.

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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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DISTRICT OF COLUMBIA

MFC-DC Formulary Changes Reminder

- Effective January 1, 2026
- 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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POS Beneficiary Notice Forms

MedStar Family Choice

DISTRICT OF COLUMBIA

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

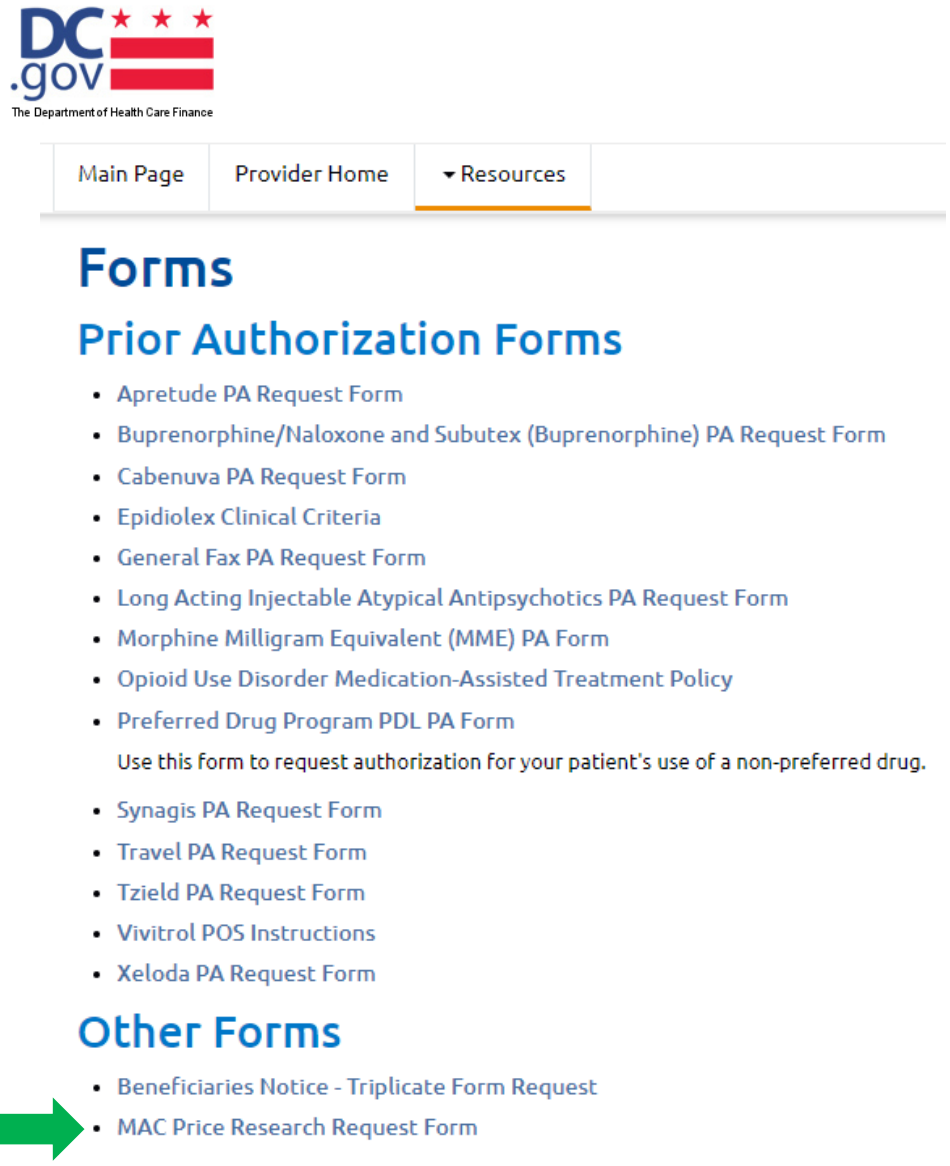
MedStar Family Choice

DISTRICT OF COLUMBIA

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.*



MedStar Family Choice
DISTRICT OF COLUMBIA

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

CVSHealth

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

MedStar Family Choice
DISTRICT OF COLUMBIA

MFC-District of Columbia
Office Information

MedStar Family Choice – DC Office:

3007 Tilden Street NW POD 3N

Washington, DC 20008

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

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Questions?

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DHCF Quarterly Pharmacy Forum-1Q2026
March 17th & 18th 2026

Leslie Addison, Manager Pharmacy Services

HSCSN

Agenda

- Drug Formulary Updates
  - April 1, 2026
- Pharmacy Update
  - 7 Day Emergency Fills
  - DAW 2
- Pharmacy Service Information

Drug Formulary Updates

1st Quarter 2026

Additions *April 1, 2026*

Drug	Preferred Non-Preferred	Brand Generic	Criteria
Eliquis (apixaban) 0.15mg capsule 0.5mg, 1.5mg, 2mg tablet	Preferred	Brand	No PA req
Ibtrozi (talerectinib) 200mg capsule	Preferred	Brand	PA, SP, QL
Tremfya Inj (guselkumab) 10mg/ml, 200mg/20ml	Preferred	Brand	PA, SP, QL
Tyvaso (treprostinil) DPI Main Kit , 80mcg	Preferred	Brand	PA, SP, QL
Xeljanz (tofacitinib) oral 1mg/ml, 5mg, 10mg, 11mg ER, 22mg ER tablets	Preferred	Brand	PA,SP, QL

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Deletions *April 1, 2026*

Drug	Brand/Generic
Adalimumab-BWWD inj 40mg/0.4ml	Brand
Alendronate sodium tablet 5mg	Generic
Ciprofloxacin tablet 100mg	Generic
Extavia inj 0.3mg kit	Brand
Flurbipropen tablet 50mg, 100mg	Generic
Orapred ODT tablet 10mg, 15mg, 30mg	Brand

*Deletion removed by Generic Product Indicator (GPI)

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Deletions *April 1, 2026*

Drug	Brand/Generic
Skyrizi (risankizumab)solution 60mg/ml, Injectable 150mg/ml, 180mg/1.2ml, 360mg/2.4ml	Brand
Ribavirin 200mg tablet, capsule	Generic
Rinvoq (upadacitinib) ER 15mg, 30mg, 45mg tablet	Brand
Zorbtive (somatropin) injectable 8.8mg/ml	Brand
Zyvox (linezolid) oral solution 2mg/ml	Brand

*Deletion removed by Generic Product Indicator (GPI)

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Prior Authorization (PA)/ Utilization Management (UM) Change

April 1, 2026

Drug	Brand/Generic	Changes
Dofetilide 125mg, 250mg, 500mg capsules	Generic	No PA required

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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/drug-formulary

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7 Days Emergency Fill (7DEF) Update
Dispense As Written (DAW)
1st Quarter 2026

7-Day Emergency Fill (7DEF) Override Code Opportunity For Improvement

7-Day Emergency Fill Billing Issues-

- Incorrect submission of the 7DEF override code.
- Two (2) override-code paid prescription fills.

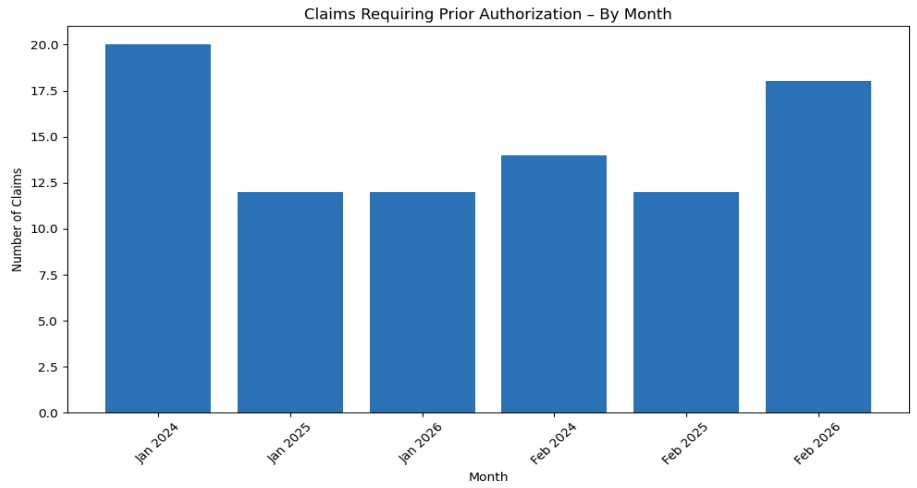
Why This Matters-

- To prevent unnecessary delays in medication access.
- To reduce avoidable denials and rework.
- To comply with the DHCF requirement for 72 hours prescription fill when PA is required.

7DEF Claims Requiring Prior Authorization Follow-Up

January 2024	January 2025	January 2026
20	**12**	**12**

February 2024	February 2025	February 2026
14	**12**	**18**



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7 Day Emergency Fills (7DEF) Rejected Pharmacy Claims

- 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 monitor and follow-up on paid 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

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7- Day Emergency Fills (7DEF) Rejected Pharmacy Claim

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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7- Day Emergency Fills (7DEF) Maximum Override Claim Paid

Rejected Claim Status

Claim Status
Reject Code - Description: 70 - NDC/Product/Service Not Covered
Reject Code - Description: 76 - Plan Limitations Exceeded
Reject Code - Description: MR - Product Not On Formulary
Settlement Code - Description: 02512 - NDC IS NOT COVERED
Settlement Code - Description: 00038 - MAXIMUM REFILL LIMIT EXCEEDED
Settlement Code - Description: 10572 - PRODUCT NOT ON FORMULARY
Local Messages: FOR 7 DS O/R, USE PAMC 11112222333/ NOTIFY MD OF PA OR ALTERNATIVE REQ NON-FORMULARY DRUG, CONTACT PRESCRIBER
MAX OVERRIDE FILLS EXCEEDED

Claim Data
Reversal Date:
BIN: 004336
Submitted Processor Control#: MCAIDADVR
Submitted Group: RX6534
COB Claim Indicator: 1
Emergency Override for Lock-ins :
Prior Authorization Reason Code:1
Paid Days: 7
Paid Quantity: 5.0
Override ID: 11112222333

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Dispense As Written (DAW) Reminders

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Dispense As Written (DAW) Code Restrictions and Exceptions

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

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HSCSN Pharmacy Services
Helpful Information

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

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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
  - -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)

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General Prior Authorization (PA)

The process is completed through the CVS Caremark Utilization Team.

✓ **Phone**

Pharmacist/Prescriber

Contact CVS Caremark PA Department (1-877-433-7643)

✓ **Fax**

Prescriber

- 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

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

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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

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Pharmacy Provider Forum

Tracey Davis, PharmD

March 2026

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

February 2026 P&T changes

The following products will be **added** to the formulary on 4/1/26:

- Humulin® N KwikPen 100 unit/mL subcutaneous pen(QL of 30/30)
- HumuLIN 70/30 KwikPen Subcutaneous Suspension Pen-injector (70-30) 100 UNIT/ML (QL of 30/30)
- naltrexone 50 mg
- Starjemza Subcutaneous Solution Syringes (QL max 1 dose/56 days for maintenance; 2 doses/28 days for loading dose)
- Starjemza Intravenous Solution 130 MG/26ML (QL 4 doses per 180 days)

February Formulary changes

The following products will be **added** to the formulary on 4/1/26:

- Theophylline ER Oral Tablet Extended Release 12 Hour 100 MG, 200 MG
- Ustekinumab-aauz Subcutaneous Solution Prefilled Syringes 45(QL max 1 dose/84 days for maintenance; 2 doses/28 days for loading dose)
- Adalimumab-bwwd Subcutaneous Solution Auto-injector 40 MG/0.4ML, Prefilled Syringe 40 MG/0.4ML (QL max 4 doses/28 days for maintenance; 8 for loading dose)
- Cryselle Oral Tablet 0.3-30 MG-MCG
- disulfiram 250, 500 mg (QL of 30 tablets)

Benefit Details

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

March 17-18, 2026

Wellpoint
District of Columbia

Agenda

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

Key Formulary Changes

EFFECTIVE FOR ALL PATIENTS ON MAY 1, 2026			
ANTIHISTAMINES	CARBINOXAMINE 4MG TABLET CARBINOXAMINE 4MG/5ML ORAL SOLUTION	NON-PREFERRED	CETIRIZINE/CETIRIZINE-D FEXOFENADINE/ FEXOFENADINE-D LORATADINE/ LORATADINE-D LEVOCETIRIZINE TABLETS (OTC) CHLORPHENIRAMINE 4 MG TABLETS CHLORPHENIRAMINE 12 MG ER TABLETS
H-2 ANTAGONISTS**	FAMOTIDINE 20MG TABLET (RX)	PREFERRED	N/A

Key Utilization Management Changes

UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN MAY 1,2026 NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY		
ANTHELMINTICS	IVERMECTIN 6MG TABLET	UPDATE QL 4 TABLETS PER FILL; 1 FILL PER 90 DAYS
ANTIASTHMATIC - MONOCLONAL ANTIBODIES	EXDENSUR 100MG/ML PREFILLED PEN/SYRINGE	ADD PA AND QL 1 PEN/SYRINGE EVERY 6 MONTHS
ANTICOAGULANTS	ELIQUIS 0.5MG TABLETS FOR ORAL SUSPENSION	UPDATE QL ~~592 TABLETS PER 30 DAYS~~ 32 TABLETS PER DAY
ANTICOAGULANTS	ELIQUIS SPRINKLE 0.15MG POWDER FOR ORAL SUSPENSION	UPDATE QL ~~74 CAPSULES PER 30 DAYS~~ 4 CAPSULES PER DAY
ANTICONVULSANTS	SUBVENITE 10MG/1ML ORAL SUSPENSION	ADD PA AND QL 50 ML PER DAY
ANTIDEPRESSANTS	ESCITALOPRAM 15MG CAPSULE	ADD ST AND QL 1 CAPSULE PER DAY
ANTIEMETICS	ONDANSETRON 4MG/5ML ORAL SOLUTION	UPDATE QL ~~8 ML PER DAY~~ 240 ML PER 30 DAYS
ANTIEMETICS	ANZEMET 50MG TABLETS	UPDATE QL 5 TABLETS PER 30 DAYS
ANTIFUNGALS - TOPICAL	ECONAZOLE 1% FOAM FORMULA 7 1% GEL KETODAN 2% FOAM	ADD ST
ANTIFUNGALS - TOPICAL	ECONAZOLE 1% FOAM	ADD QL 70 GM PER 30 DAYS
ANTIFUNGALS - TOPICAL	KETODAN 2% FOAM	ADD QL 100 GM PER 30 DAYS

Key Utilization Management Changes

ANTIHISTAMINES	DESLORATADINE 0.5MG/ML ORAL SOLUTION	ADD ST AND QL 10 ML PER DAY
ANTIHYPERLIPIDEMICS	REPATHA 140MG/ML PREFILLED SYRINGE/AUTO-INJECTOR	UPDATE QL 3 ~~2~~ PREFILLED SYRINGES/AUTO-INJECTORS PER 28 DAYS
ANTIHYPERTENSIVES	JAVADIN 0.02MG/ML INJECTION	ADD PA AND QL 60 ML PER DAY
ANTI-INFECTIVE AGENTS - MISC.	TYZAVAN 500MG INJECTION TYZAVAN 750MG INJECTION TYZAVAN 1GM INJECTION TYZAVAN 1.25GM INJECTION TYZAVAN 1.5GM INJECTION TYZAVAN 1.75GM INJECTION TYZAVAN 2GM INJECTION	ADD QL 2 VIALS/BAGS PER DAY
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	INLEXZO 225MG IMPANT	ADD PA
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	INLURIYO 200MG TABLET	ADD PA AND QL 2 TABLETS PER DAY
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	KEYTRUDA QLEX INJECTION	ADD PA
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	KEYTRUDA QLEX 395MG/2.4ML INJECTION	ADD QL 2.4 ML (1 VIAL) PER 21 DAYS
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	KEYTRUDA QLEX 790MG/4.8ML INJECTION	ADD QL 4.8 ML (1 VIAL) PER 42 DAYS
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	KOSELUGO ORAL GRANULES	ADD PA
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	KOSELUGO 5MG ORAL GRANULE	ADD QL 20 ORAL GRANULES PER DAY
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	KOSELUGO 7.5MG ORAL GRANULE	ADD QL 6 ORAL GRANULES PER DAY

Key Utilization Management Changes

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	FASLODEX 250MG/5ML INJECTION	REMOVE PA
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	HYRNUO 10MG CAPSULE	ADD PA AND QL 4 TABLETS PER DAY
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	BLENREP 70MG INJECTION	ADD PA
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	KOMZIFTI 200MG CAPSULE	ADD PA AND QL 3 CAPSULES PER DAY
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES*	POHERDY INJECTION	ADD PA
ANTIPARKINSON AND RELATED THERAPY AGENTS	DHIVY 25-100MG TABLET	REMOVE QL

Key Utilization Management Changes

ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	CYLTEZO (ADALIMUMAB-ADBM) CROHN'S DISEASE, ULCERATIVE COLITIS OR HIDRADENITIS SUPPURATIVA STARTER PACKAGE 40MG/0.8ML PEN	UPDATE QL 1 PACK (~~28 DAY SUPPL~~Y, ONE TIME FILL)
	CYLTEZO (ADALIMUMAB-ADBM) PSORIASIS OR UVEITIS STARTER PACKAGE 40MG/0.8ML PEN	
	CYLTEZO (ADALIMUMAB-ADBM) CROHN'S DISEASE, ULCERATIVE COLITIS OR HIDRADENITIS SUPPURATIVA STARTER PACKAGE 40MG/0.4ML PEN	UPDATE QL 1 PACK (~~28 DAY SUPPL~~Y, ONE TIME FILL)
	CYLTEZO (ADALIMUMAB-ADBM) PSORIASIS OR UVEITIS STARTER PACKAGE 40MG/0.4ML PEN	
	HUMIRA (ADALIMUMAB) PEDIATRIC ULCERATIVE COLITIS STARTER PACK 80MG/0.8ML PREFILLED SYRINGE PEN	
	HUMIRA (ADALIMUMAB) PEDIATRIC CROHN'S DISEASE STARTER PACK 80MG/0.8ML PREFILLED SYRINGE	
	HUMIRA (ADALIMUMAB) PEDIATRIC CROHN'S DISEASE STARTER PACK 80MG/0.8ML + 40MG/0.4ML PREFILLED SYRINGE	
	HUMIRA (ADALIMUMAB) CROHN'S DISEASE/ULCERATIVE COLITIS/ HIDRADENITIS SUPPURATIVA STARTER PACK 80MG/0.8ML PREFILLED PEN	
	HUMIRA (ADALIMUMAB) CROHN'S DISEASE/ULCERATIVE COLITIS/ HIDRADENITIS SUPPURATIVA STARTER PACK 40MG/0.8ML PREFILLED PEN	
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	HUMIRA (ADALIMUMAB) PSORIASIS/UVEITIS/ADOLESCENT HIDRADENITIS SUPPURATIVA STARTER PACK 80MG/0.8ML + 40MG/0.4ML PREFILLED PEN	
	IDACIO (ADALIMUMAB-AACF) CROHN'S DISEASE/ULCERATIVE COLITIS/HIDRADENITIS SUPPURATIVA STARTER PACK 40MG/0.8ML PREFILLED PEN	
	HYRIMOZ (ADALIMUMAB-ADAZ) CROHN'S DISEASE AND ULCERATIVE COLITIS OR HIDRADENITIS SUPPURATIVA STARTER PACKAGE 80MG/0.8ML PEN	

Key Utilization Management Changes

ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	HYRIMOZ (ADALIMUMAB-ADAZ) CROHN'S DISEASE, ULCERATIVE COLITIS OR HIDRADENITIS SUPPURATIVA STARTER PACKAGE 80MG/0.8ML + 40MG/0.4ML PEN	UPDATE QL 1 PACK (~~28 DAY SUPPLY~~, ONE TIME FILL)
	HYRIMOZ (ADALIMUMAB-ADAZ) PLAQUE PSORIASIS/UVEITIS/ADOLESCENT HIDRADENITIS SUPPURATIVA STARTER PACKAGE PACK 80MG/0.8ML + 40MG/0.4ML PEN	
	HYRIMOZ (ADALIMUMAB-ADAZ) PEDIATRIC CROHN'S DISEASE STARTER PACK 80MG/0.8ML PREFILLED SYRINGE	UPDATE QL 1 PACK (~~28 DAY SUPPLY~~, ONE TIME FILL)
	HYRIMOZ (ADALIMUMAB-ADAZ) PEDIATRIC CROHN'S DISEASE STARTER PACK 80 MG/0.8ML + 40MG/0.4ML PREFILLED SYRINGE	
	IDACIO (ADALIMUMAB-AACF) PSORIASIS OR UVEITIS STARTER PACK 40MG/0.8ML PREFILLED PEN	
	YUFLYMA (ADALIMUMAB-AATY) CROHN'S DISEASE, ULCERATIVE COLITIS OR HIDRADENITIS SUPPURATIVA STARTER PACK 80 MG/0.8 ML PREFILLED AUTOINJECTOR	
	YUFLYMA (ADALIMUMAB-AATY) PSORIASIS STARTER PACK 40MG/0.4ML PREFILLED AUTOINJECTOR	
	YUFLYMA (ADALIMUMAB-AATY) PSORIASIS STARTER PACK 80MG/0.8ML + 40MG/0.4ML PREFILLED AUTOINJECTOR	
	YUFLYMA (ADALIMUMAB-AATY) CROHN'S DISEASE, PEDIATRIC CROHN'S DISEASE, ULCERATIVE COLITIS OR HIDRADENITIS SUPPURATIVA STARTER PACK 40MG/0.4ML PREFILLED AUTOINJECTOR	
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	YUFLYMA (ADALIMUMAB-AATY) PEDIATRIC CROHN'S DISEASE STARTER PACK 80MG/0.8ML + 40MG/0.4ML PREFILLED SYRINGE YUFLYMA (ADALIMUMAB-AATY) PEDIATRIC CROHN'S DISEASE STARTER PACK 80MG/0.8ML PREFILLED SYRINGE	

Key Utilization Management Changes

ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	SIMLANDI (ADALIMUMAB-RYVK) 80MG/0.8ML AUTOINJECTOR	ADD QL 2 SYRINGES PER 28 DAYS
BONE DENSITY REGULATORS*	BILDYOS, BOSAYA, ENOBY 60MG/ML PREFILLED SYRINGE OR VIAL	ADD PA AND QL 60 MG (1 PREFILLED SYRINGE OR 1 VIAL) EVERY 6 MONTHS
BONE DENSITY REGULATORS*	AUKELSO, BILPREVDA, JUBEREQ, XTRENBO 120MG/1.7ML VIAL	ADD PA AND QL 1 VIAL PER 28 DAYS
BONE DENSITY REGULATORS*	OSVYRTI 60MG/1ML PREFILLED SYRINGE	ADD PA AND QL 60 MG (1 PREFILLED SYRINGE) EVERY 6 MONTHS
DERMATOLOGICALS	SPEVIGO 300MG/2ML PREFILLED SYRINGE	ADD QL 1 PREFILLED SYRINGE PER 28 DAYS*
DERMATOLOGICALS	PYZCHIVA 45MG/0.5ML VIAL	ADD QL 1 VIAL PER 84 DAYS (12 WEEKS)
DERMATOLOGICALS	PYZCHIVA 45MG/0.5ML SINGLE-USE PREFILLED SYRINGE/AUTOINJECTOR PYZCHIVA 90 MG/1 ML SINGLE-USE PREFILLED SYRINGE/AUTOINJECTOR	ADD QL 1 SYRINGE/AUTOINJECTOR PER 84 DAYS (12 WEEKS)

Key Utilization Management Changes

DERMATOLOGICALS	STEQEYMA 45MG/0.5ML VIAL	ADD QL 1 VIAL PER 84 DAYS (12 WEEKS)
DERMATOLOGICALS	ZORYVE 0.15% AND 0.05% CREAM	ADD PA
DERMATOLOGICALS	ZORYVE 0.05% CREAM	ADD QL 60 GM PER 30 DAYS
DERMATOLOGICALS	ZORYVE 0.3% FOAM	ADD ST
DIURETICS	ENBUMYST 0.5MG UNIT DOSE NASAL SPRAY	ADD PA AND QL 12 NASAL SPRAYS PER 30 DAYS
DIURETICS	LASIX ONYU KIT AND STARTER KIT	ADD PA A
DIURETICS*	LASIX ONYU 80MG/2.67ML KIT	ADD QL 6 KITS PER 30 DAYS
DIURETICS*	LASIX ONYU STARTER KIT	ADD QL 1 KIT PER 8 MONTHS
DIURETICS	ORMALVI 50MG TABLET	ADD PA AND QL 4 TABLETS PER DAY
ENDOCRINE AND METABOLIC AGENTS - MISC.	FORZINITY 280MG/3.5ML VIAL	ADD PA AND QL 4 VIALS PER 28 DAYS
ENDOCRINE AND METABOLIC AGENTS - MISC.	PALSONIFY 20MG TABLET PALSONIFY 30MG TABLET	ADD PA AND QL 20 MG: 2 TABLETS PER DAY 30 MG: 4 TABLETS PER DAY
ENDOCRINE AND METABOLIC AGENTS - MISC.	HARLIKU 2MG TABLET	ADD ST
ENDOCRINE AND METABOLIC AGENTS - MISC.	REDEMPLO 25MG/0.5ML SYRINGE	ADD PA AND QL 1 SYRINGE EVERY 3 MONTHS
ENDOCRINE AND METABOLIC AGENTS - MISC.	TRYNGOLZA 80MG/0.8ML INJECTION	ADD ST
ENDOCRINE AND METABOLIC AGENTS - MISC.	LYNKUET 60MG CAPSULE	ADD PA AND QL 2 CAPSULES PER DAY
GASTROINTESTINAL AGENTS - MISC.	OMVOH 200MG/2ML PREFILLED PEN/SYRINGE	1 PENS/SYRINGE [1 CARTON] PER 28 DAYS (4 WEEKS)
GASTROINTESTINAL AGENTS - MISC.	OMVOH 300MG/15ML SINGLE-DOSE VIAL	UPDATE QL 9 VIALS TOTAL ~~TO LAST 12 WEEKS~~; ONE TIME FILL

Key Utilization Management Changes

GASTROINTESTINAL AGENTS - MISC.	SKYRIZI 180MG/ 1.2ML SYRINGE	ADD QL 1 PREFILLED SYRINGE PER 56 DAYS (8 WEEKS)
GASTROINTESTINAL AGENTS - MISC.	SKYRIZI 600MG/10ML SINGLE-DOSE VIAL	UPDATE QL 6 VIALS TOTAL ~~TO LAST 12 WEEKS~~; ONE TIME FILL
GASTROINTESTINAL AGENTS - MISC.	TREMFYA (GUSELKUMAB) INDUCTION PACK FOR ULCERATIVE COLITIS OR CROHN'S DISEASE 200MG/2ML PEN	ADD QL 3 PACKS TOTAL; ONE TIME SUPPLY
GASTROINTESTINAL AGENTS - MISC.	TREMFYA 200MG/20ML SINGLE-DOSE VIAL	UPDATE QL 3 VIALS TOTAL ~~TO LAST 12 WEEKS~~; ONE TIME FILL
GASTROINTESTINAL AGENTS - MISC.	STELARA 130MG/26ML (5MG/ML) VIAL USTEKINUMAB 130MG/26ML (5MG/ML) VIAL SELARSDI (USTEKINUMAB-AEKN) 130MG/26ML (5MG/ML) VIAL IMULDOSA (USTEKINUMAB-SRLF) 130MG/26ML (5MG/ML) VIAL PYZCHIVA (USTEKINUMAB-TTWE) 130MG/26ML (5MG/ML) VIAL OTULFI (USTEKINUMAB-AAUZ) 130MG/26ML (5MG/ML) VIAL STARJEMZA (USTEKINUMAB-HMNY) 130MG/26 ML (5 MG/ML) VIAL STEQEYMA (USTEKINUMAB-STBA) 130MG/26 ML (5MG/ML) VIAL WEZLANA (USTEKINUMAB-AUUB) 130MG/26 ML (5MG/ML) VIAL YESINTEK (USTEKINUMAB-KFCE) 130MG/26 ML (5MG/ML) VIAL	UPDATE DOSING BODY WEIGHT 55 KG OR LESS: 2 VIALS (~~8 WEEK SUPPLY~~, ONE TIME FILL) BODY WEIGHT MORE THAN 55KG TO 85 KG: 3 VIALS (~~8 WEEK SUPPLY~~, ONE TIME FILL) BODY WEIGHT MORE THAN 85 KG [MAX LIMIT]: 4 VIALS (~~8 WEEK SUPPLY~~, ONE TIME FILL)
GASTROINTESTINAL AGENTS - MISC.	CIMZIA (CERTOLIZUMAB PEGOL) 200MG/ML STARTER KIT	UPDATE QL 1 STARTER KIT (~~(28 DAY SUPPLY~~, ONE TIME FILL)

Key Utilization Management Changes

GENITOURINARY AGENTS - MISCELLANEOUS	VOYXACT 400MG/2ML PREFILLED SYRINGE	ADD PA AND QL 1 PREFILLED SYRINGE PER 4 WEEKS
H-2 ANTAGONISTS	FAMOTIDINE ORAL SUSPENSION	REMOVE PA
HEMATOLOGICAL AGENTS - MISC.	WAYRILZ 400MG TABLET	ADD PA AND QL 2 TABLETS PER DAY
HEMATOPOIETIC AGENTS*	ARMLUPEG 6MG/0.6ML PREFILLED SYRINGE	ADD PA AND QL 2 SYRINGES PER 28 DAYS
IMMUNE SERUMS*	GAMMAGARD LIQUID ERC 10% INJECTION QIVIGY 10% INJECTION	ADD PA
INSULIN	KIRSTY U-100 (INSULIN ASPART-XJHZ) PEN	ADD ST AND QL 30 ML PER 30 DAYS
INSULIN*	HUMALOG TEMPO U-200 PEN	ADD QL 30 ML PER 30 DAYS
LOCAL ANESTHETICS – TOPICAL*	BONDLIDO 10% PATCH	ADD PA AND QL 2 PATCHES PER DAY
METABOLIC AGENTS - MISC.*	KYGEVVI POWDER FOR ORAL SOLUTION	ADD PA AND QL 16 PACKETS PER DAY
MISCELLANEOUS THERAPEUTIC CLASSES	RHAPSIDO 25MG TABLET	ADD PA AND QL 2 TABLETS PER DAY
MISCELLANEOUS THERAPEUTIC CLASSES	SYLVANT 100MG INJECTION SYLVANT 400MG INJECTION	REMOVE PA
NEUROMUSCULAR AGENTS	RADICAVA 30MG/ 100ML INJECTION	ALL QL 2,000 ML PER 28 DAYS
NEUROMUSCULAR AGENTS*	RADICAVA 60MG/ 100ML INJECTION	ADD QL 1,000 ML PER 28 DAYS
OPHTHALMIC AGENTS*	EYDENZELT 2MG VIAL & SYRINGE	ADD PA AND QL DIABETIC MACULAR EDEMA, DIABETIC RETINOPATHY, NEOVASCULAR “WET” AGE-RELATED MACULAR DEGENERATION, RETINAL VEIN OCCLUSION: 2 MG PER EYE; EACH EYE MAY BE TREATED AS FREQUENTLY AS EVERY 4 WEEKS. RETINOPATHY OF PREMATURITY: 0.4 MG PER EYE; EACH EYE MAY BE TREATED AS FREQUENTLY AS EVERY 10 DAYS.
OPHTHALMIC AGENTS*	ZOLYMBUS 0.01% OPHTHALMIC GEL	30 SINGLE-DOSE UNITS PER 30 DAYS
RESPIRATORY AGENTS - MISC.	GLASSIA 4000MG VIAL GLASSIA 5000MG VIAL	ADD DOSING 60 MG/KG ONCE PER WEEK
RESPIRATORY AGENTS - MISC.	JASCAYD 9MG TABLET JASCAYD 18MG TABLET	ADD PA AND QL 2 TABLETS PER DAY

Pharmacy Network Updates

Pharmacy Network Search

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

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

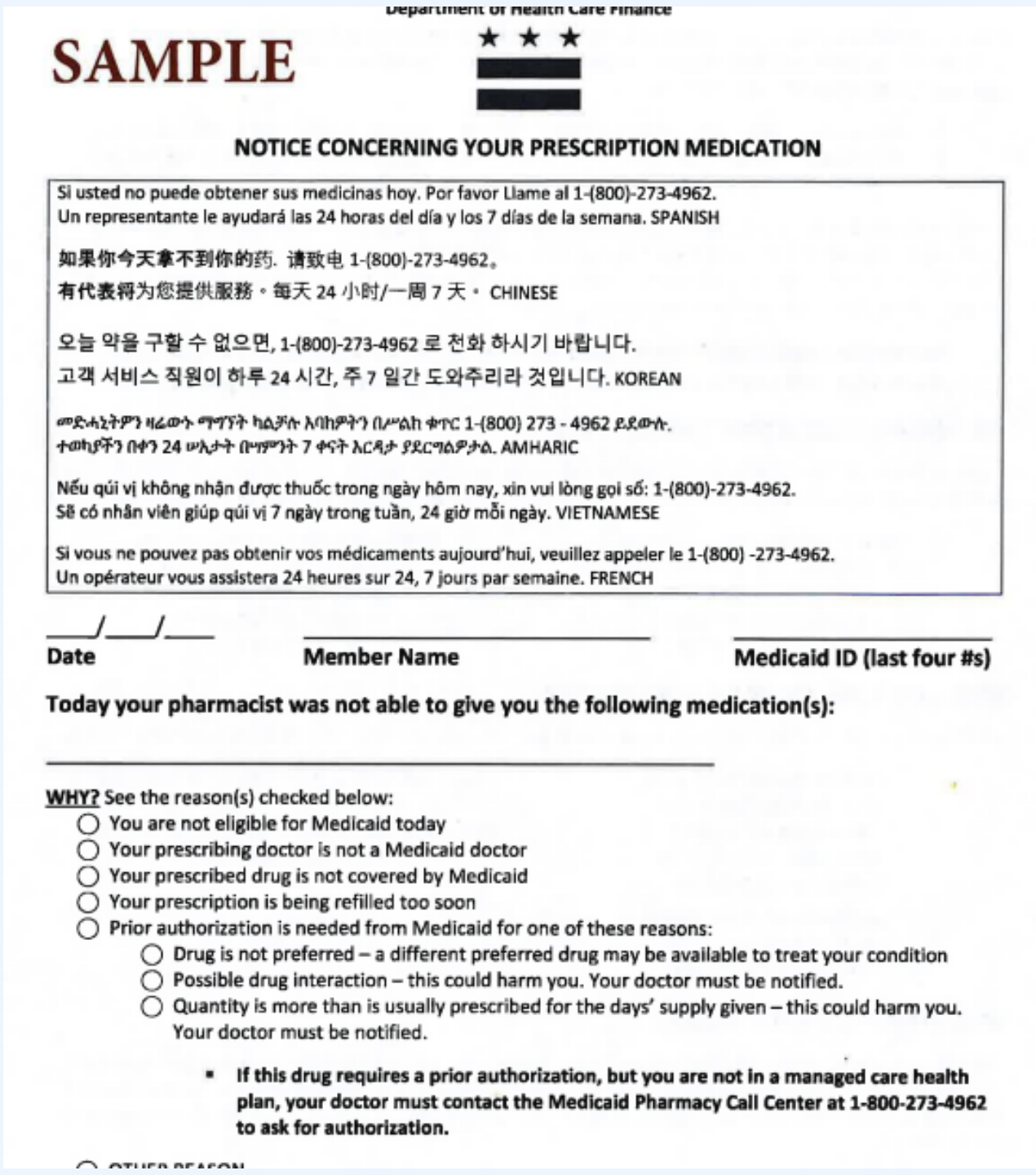
Reminder: Beneficiary Notice Forms

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.
ተወካዎችን 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: **800-600-4441**

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

Pharmacy Resources

[Medicaid Pharmacy Benefits in Washington, DC | Wellpoint]

The Sydney Health mobile app makes it easy to find a doctor, access your ID card, and chat with a live representative.

Thank you!

Questions?

Insert appropriate disclosure from the Legal Disclosure Database

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UnitedHealthcare DC Dual Choice

Nicole L Zvosecz, PharmD

March 2026

United Healthcare

Plan Overview

INTEGRATED DSNP BENEFIT COMBINING MEDICARE PART D AND DISTRICT DEFINED MEDICAID COVERAGE

ALL MEMBERS HAVE PART D COVERAGE FOR PRESCRIPTION DRUGS

WRAP BENEFIT/OTC'S AND PART B COST SHARE IS DETERMINED BY MEDICAID

Pharmacy Plan Overview 2026

- Mail Order Benefit
- Members have 1 ID card for both Medicare and Medicaid
- ~~Members have a zero copay on pharmacy benefit medications~~
- Most Part D exclusions apply such as weight loss and cosmetic medications
- Medicaid wrap benefit is the District defined OTC and infertility list
- 100 day supplies available on most drugs except Specialty meds.

2026 Pharmacy Copay changes

- Previously UHC was able to offer zero copays on Part D drugs through CMS's VBID program
- VBID ended in 2025
- Now in 2026 most member's will be responsible for their Part D copays
- Part D copays are based on the member's Low-Income Subsidy (LIS) level or "Extra Help" as determined by the Social Security Administration (SSA)

DC Dual Choice Part D Copays 2026

- All Tier 1 copays are still $0.00
- All Medicaid drugs (OTC and infertility) are still $0.00
- Tiers 2 to 5 drugs follow the chart below
- Tiering is found on the formulary and formulary look up tool

2026 CMS Part D DSNPs Low Income Subsidy (LIS) Cost-Share

Low Income Subsidy	Deductible	Cost-Share (brand)	Cost-Share (generic)	Catastrophic Coverage
LIS1	$0.00	$12.65	$5.10	$0.00
LIS2	$0.00	$4.90	$1.60	$0.00
LIS3 (LTC)	$0.00	$0.00	$0.00	$0.00

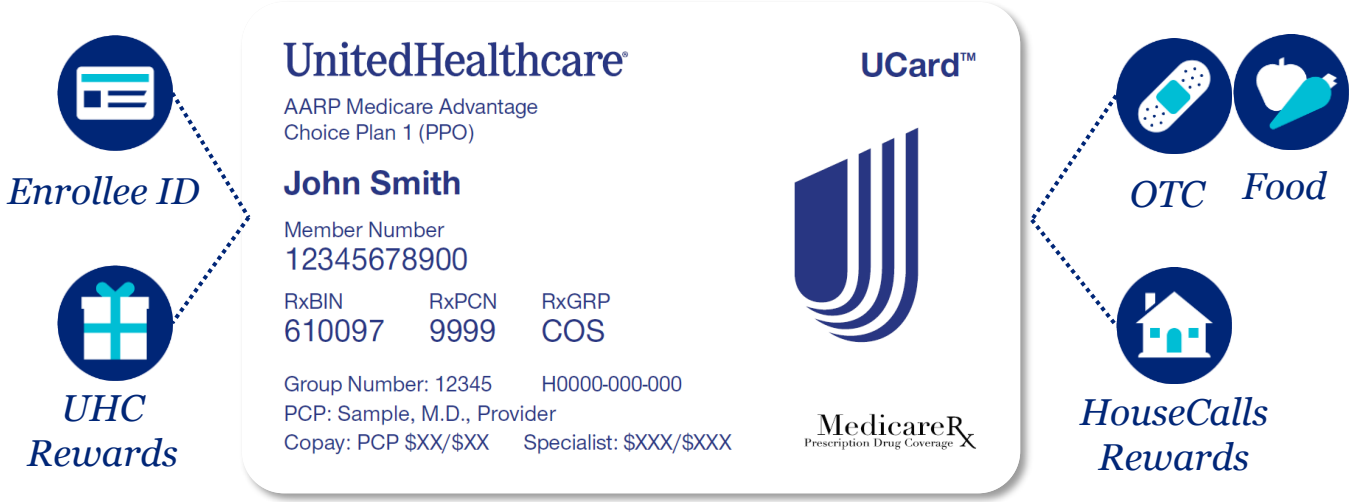
Pharmacy Claims Processing Information

Contract	Plan	Plan ID	BIN	PCN	Group	Part D Claims Coverage	OTC Claims Coverage	U CARD use for OTC
H2406-53	LPPO HIDE Full	MPDCSP	610097	9999	MPDCSP	Yes	Yes	Yes
H2406-53	LPPO HIDE Partial	MPDCSP	610097	9999	MPDCSP	Yes	No	Yes
H2406-99	LPPO QMB Partial	MPDCSP	610097	9999	MPDCSP	Yes	No	Yes
H2406-99	LPPO QMB	MPDCSP	610097	9999	MPDCSP	Yes	No	Yes
H7464-10	HMO HIDE Full	MPDCSP	610097	9999	MPDCSP	Yes	Yes	Yes
H7464-10	HMO HIDE Partial	MPDCSP	610097	9999	MPDCSP	Yes	No	Yes

The UCard –An OTC Option

It's the enrollee ID and so much more…

UCard Front



UCard Back

New in 2023

Utilities

- The UCard will be the member ID and replace prior payment cards
- Benefit credit (OTC/Food/Utilities) and rewards (UHC and HouseCalls) purses will be consolidated onto UCard
- The barcode on the back can be scanned at any of the **55K+ retail locations** in the S3 network to buy approved items with available benefit or reward funds
- S3 network retailers have integrated point-of-sale technology to do a real-time eligibility item check and pull funds from respective purses for payment

Over the Counter/Food/ Utilities Overview

	Dual Choice	Dual Choice One	Dual Choice Unity
Benefit	$115 per month Over the Counter (OTC), food allowance, and utilities combined credit (expires monthly) UHC Medicaid approved OTC are covered under Pharmacy benefit	$188 per month OTC, food allowance, and utilities combined credit (expires monthly) UHC Medicaid approved OTC are covered under Pharmacy benefit	$57 per month OTC, food allowance, and utilities, combined credit (expires monthly)
Over the Counter/Food	Store Finder (healthybenefitsplus.com)	Store Finder (healthybenefitsplus.com)	Store Finder (healthybenefitsplus.com)

DSNP Formulary Rules Part D

There are no negative changes mid-year for Medicare Part D

All negative changes occur when the plan turns over Jan 1st each year

Approvals are for the remaining calendar year

Members receive an Annual Notice of Change each year to prepare them for any upcoming negative changes

New Additions to the Formulary 2026

Cresemba

fosfomycin (generic Monurol)

Nuzyra

Kineret

Ebglyss

Tremfya

Steqeyma 45mg, 90mg

Yesintek 45mg, 90mg

Astragraf WL

Novolog vial, Penfill, Flexpen

insulin Aspart vial, Penfill, Flexpen

dapagliflozin

Fiasp via, Penfill, Flexpen

Novolin R Flexpen

mesalamine ER (generic Apriso)

glycopyrrolate oral tab

Voquenza

estradiol gel 0.06%

dabigatran

rivaroxaban 2.5mg

Xarelto oral suspension

Jubboni

Wyost

tolvaptan

Zorye

Orenitram

Kaletra Oral solution

tolvaptan

Rezdiffra

Bafiertam

Abilify Asimtufii

Trikafta

Winrevair

Nucala

New Non-Formulary Drugs 2026

- The following medications are non-formulary as of 1/1/2026.
- Impacted members received a letter notifying them of the change as well as covered options.
- Recommended alternatives are listed depending on medication
- Drugs with multiple indications or treatment modalities are referred to the prescriber to determine the best alternative
- Providers can submit a coverage exception if a suitable alternative is unavailable

Non-Formulary Drugs

Non-Formulary Medication	Alternative(s)
cyproheptadine oral tablet, solution	levocetirizine oral tablet, solution
Dymista Nasal Spray	azelastine 0.1% nasal spray fluticasone nasal spray
Ciloxan Ophth FML Forte Ophth TobradexST Ophth Tobrex Ophth	alternatives vary by diagnosis, speak to provider
Immunie Globulin products: Alyglo, Ascenic, Bivigam, Fiebogamma, Gammagard, Gammaked, Gammaplex, Panzyga, Privigen	Gammunex, Octagam
Jylamvo	methotrexate
Orencia	Tyenne
Berinert	Haegarda
Humira	adalimumab-aaty adalimumab-abdm

Non-Formulary Drugs

Non-Formulary Medication	Alternative(s)
diphenoxylate/atropine	loperamide
esomeprazole oral packet	esomeprazole oral capsule
glycopyrrolate oral solution	glyccopyrrolate oral tablet
meclizine 50mg tablet	ondansetron
Aralast NP Zemaira	Prolastin-C
colchicine oral capsule (genericColcrys)	colchicine oral tab (Generic Colcrys) allopurinol
Vumerity	Bafiertam
Mayzent	Bafiertam fongolimod dimethyl fumerate
cyclobenzaprine 7.5 mg oral tablet	tizanidine
Bromfenac 0.07%	alternatives vary by diagnosis, ask MD
Elestrin	estradiol gel 0.06%
Femring Imvexxy	Estradiol, Estring, Premarin, Yuvafem

Non-Formulary Drugs

Non-Formulary Medication	Alternative(s)
Rasuvo	methotrexate
Retacrit	Procrit Aranesp
Motegrity	Linzess lubiprostone Trulance
doxepin 5% cream desoximetasone 0.05% cream	alternatives vary by diagnosis, speak to provider
Tresiba	Lantus Lantus Solostar Toujeo Solostad Toujeo Max Solostar
Cycloset	glipizide meformin
Anzemet	ondansetron
Dipentum	mesalamine (generic Apriso) sulfasalazine (generic Azulfidine)

Non-Formulary Drugs

Non-Formulary Medication	Alternative(s)
butorphanol nasal solution diclofenac 1.3% patch hydromorphone oral solution tramadol ER tramadol/acetaminophen	alternatives vary by diagnosis, speak to provider
citalopram 30mg oral capsule	citalopram oral rablet escitalopram
chlordiazepoxide imipramine pamoate lorazepam intensol	alternatives vary by diagnosis, speak to provider
venlafaxine besylate ER tablet 112.5mg	venlafaxine hydrochloride oral capsule desvenlafaxine
Bevespi Aerosphere	Anoro Ellipta Stiolto Respimet
fermoterol fumarate (generic Performomist)	arformoterol tartrate
Envarsus XR	Astrgraf XL

Types of Coverage Determinations

Prior Authorization

These drugs are listed on the formulary as requiring a PA

Specific coverage criteria is posted and must be met

Coverage Exception

These drugs are not listed on the formulary

May be covered by submitting a coverage exception request demonstrating

medical necessity

Contact Information

- Enrollee Services 1-866-242-7726
- Provider Services 1-888-350-5608
- Pharmacy Help Desk 1-877-889-6510
- Pharmacy PA department 1-800-711-4555
- Pharmacy PA website OptumRx Prior Authorization- Lines of Business
- Plan Look Up: District of Columbia D-SNP Plans | UnitedHealthcare Community Plan (uhc.com)

Questions?