Quarterly Pharmacy Provider Forum

- Tuesday, June 16th
  - 1-2.30pm

- Wednesday, June 17th
  - 11-12.30pm

AGENDA

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

•Pharmacy Practice Reminders

HIV Antiretroviral Medication Coverage Reminders

HIV Treatment, PrEP and PEP medication coverage is “Carved-out” pharmacy benefit from the DC Medicaid Managed Care Plans (MCP)

For MCP members:

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

BIN 018407
PCN DCMC018407

For Alliance ICP Program Enrollees:

Treatment of HIV for Ages 18 years old and greater –
Please refer to DC Health Pharmacy Benefit Program(formerly ADAP) for coverage and enrollment questions @ dchealth.dc.gov › Pharmacy_Benefits_Program

Alliance claims with Diagnosis of PREP or PEP – Bill to FFS

3-Day Emergency Supply Rule

PDL Prior Authorization Override

Providers can override the PA requirement for a non-preferred drug by entering “3” in the Level of Service field (NCPDP Field # 418-DI).

The following restrictions will apply:

- The claim must be for a 3-day supply, except where the package must be dispensed intact;
- Covered drugs only
- A patient is allowed one PDL PA override per Generic Sequence Number (GSN) per 30 days.

Specialty Pharmacy Survey

coming soon

Survey is intended to understand how DC Specialty pharmacies manage **formulary-mandated biosimilar switches**, including operational practices, prescriber communication, and patient care impacts.

Responses will be used to a analyze current process and improve program effectiveness and patient outcomes:

- **Interchangeability & Substitution**
- **Drug Identification Processes**
- **Prescriber Notification Process**
- **Key Challenges with Biosimilar Switching**
- **Site of Care Challenges**

Fee for Service Preferred Drug List

Visit web link for agenda on drug classes review
https://dc.fhsc.com/providers/PDL.asp

Updated PDL District of Columbia Department of Health Care Finance Pharmacy Preferred Drug List

June 2026 PDL Changes

New Drug Class

- Immunomodulators, Asthma

Drug Class Changes

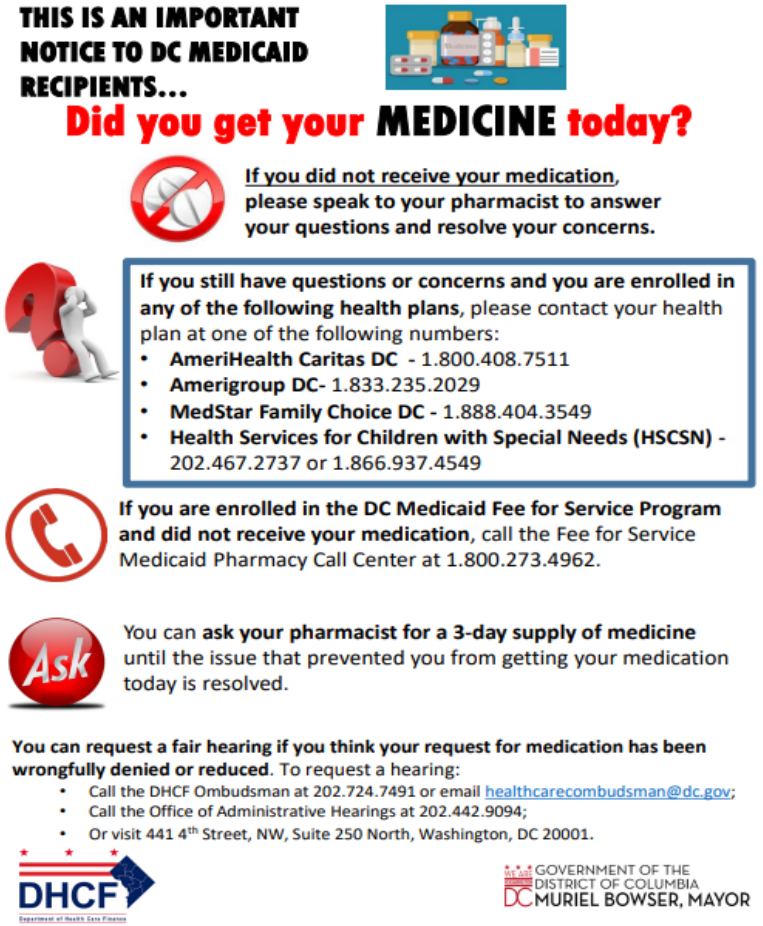
- Cytokine & CAM antagonist
- ACNE AGENTS, TOPICAL
- ANTIMIGRAINE AGENTS, OTHER, TRIPTANS
- EPINEPHRINE, SELF-ADMINISTERED
- NSAIDS
- OPHTHALMICS, ANTI-INFLAMMATORIES, DRY EYE AGENTS
- SKELETAL MUSCLE RELAXANTS
- SMOKING CESSATION
- STEROIDS, TOPICAL HIGH, LOW, Very High

Pharmacy Poster

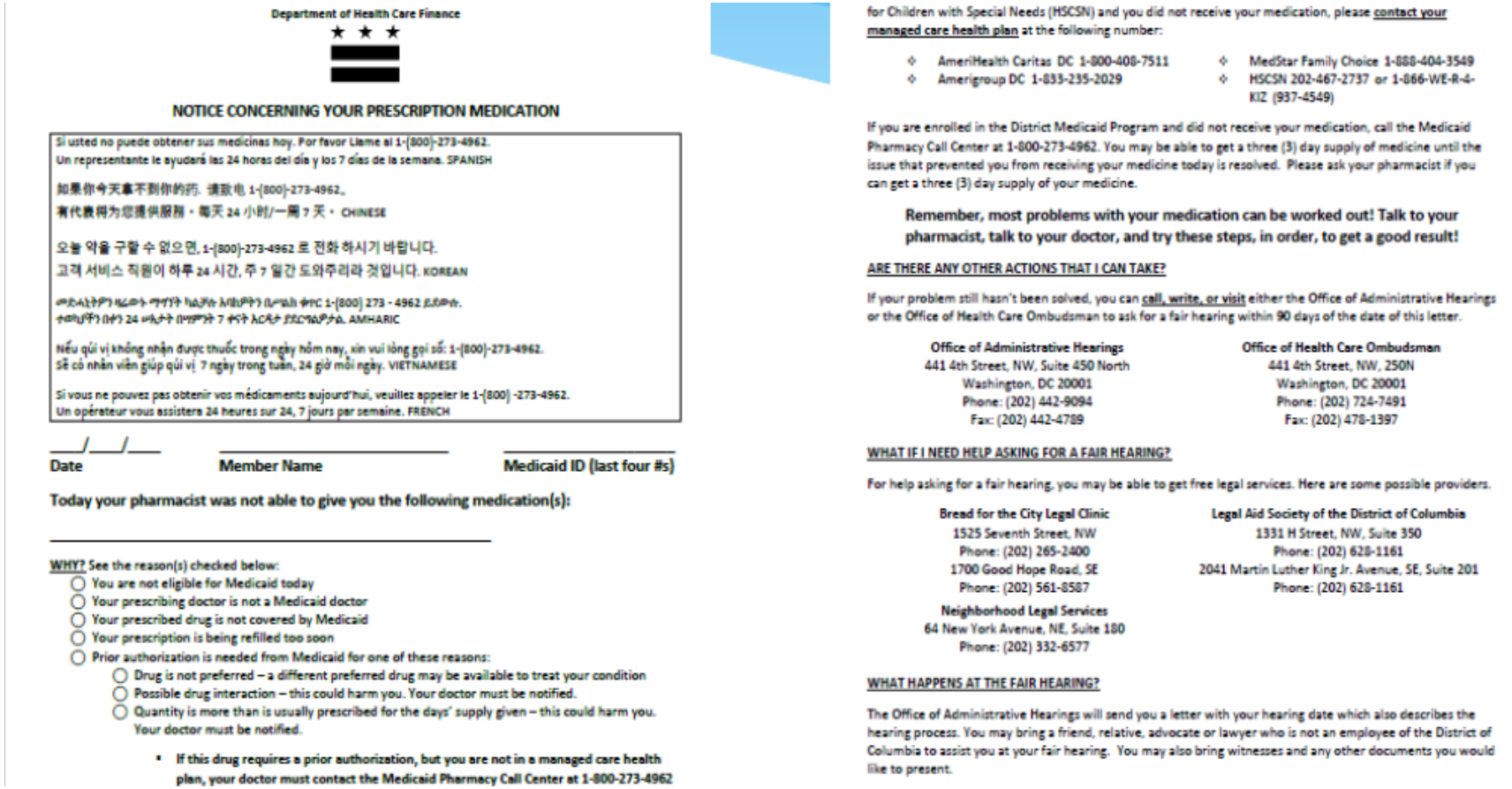
Please note Amerigroup DC is now Wellpoint DC

1-833-214-3604

- Poster modification pending approval
- New posters to be distributed to all pharmacies



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.
ተወካያችን በቀን 24 ሠዓታት በሣምንት 7 ቀናት አርዳታ 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 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

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

Message from Medicaid.Renewal@dc.gov

- Mark your calendar to attend and join the virtual meeting on Wednesday, June 17th at 2:30 p.m. by clicking this link:
- https://dcnet.webex.com/dcnet/j.php?MTID=mddfce9e3bfae3556a2a50389c977cdc0
- **Do you have questions about your Medicaid status?**
- **Email us at medicaid.renewal@dc.gov**
- **or**
- **Call us at 202.727.5355**

Join us for a meeting about **recent and upcoming changes to Alliance and Medicaid.**

When: Wednesday, June 17, 2026 @ 2:30 p.m.

Please share this meeting information with others who need to know about changes to eligibility to these programs!
Topics to be discussed include:

- Changes to Medicaid eligibility
- Updates on the Alliance program
- **Information on Medicaid Work Requirements**, including preliminary information of the content of the Interim Final Rule released earlier this month
- Other recent **eligibility changes based on new federal regulations in the "One Big Beautiful Bill"**
- Options for District Health Care Coverage
- A question and answer session on eligibility changes

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

Prime Provider Relations email
DC-FFSProviderRelations@primetherapeutics.com

DHCF Single Preferred Drug List (sPDL)

Office of the Chief Medical Officer (OCMO)
Clinical Pharmacy and Acute Providers Division

DHCF Single Preferred Drug List (sPDL) Introduction

- DHCF will transition to a Single Preferred Drug List on **4/1/2027**

DHCF Single Preferred Drug List (sPDL)

- A **Single Preferred Drug List** (sPDL) is a uniform, state-directed list of outpatient prescription drugs covered across all Medicaid fee-for-service and managed care plans, ensuring consistent coverage

DHCF Single Preferred Drug List (sPDL)
Project Objectives

Transitioning to a sPDL is intended to:

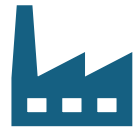
- Standardized pharmacy benefits across Managed Care Plans and Fee For Service
- Reduce variation in drug coverage
- Provide utilization management
- Strengthen the District's ability to ensure consistent access
- Improve oversight
- Support cost-effective management of pharmacy services

DHCF Single Preferred Drug List (sPDL) Overview

Governance & Policy

Contracting

Clinical Alignment



Operations & PBM

Monitoring & Compliance

DHCF Single Preferred Drug List (sPDL)

SPDL Governance Framework

Executive Oversight

Chief Medical Officer

- Final decision authority
- Issue escalation
- Governance approval

Clinical Class Review

Responsible: Clinical Lead + Clinical SMEs

Outputs

- Clinical recommendations
- Class-level decisions

Managed Care Impact & Readiness

Role: Execution & coordination

Outputs

- MCO operational impact assessment
- Readiness risks & dependencies
- Transition timelines

Communication

Transparency & alignment

Outputs

- Decision summaries (FAQs)
- Implementation updates

DHCF Single Preferred Drug List (sPDL)

Key Workflow

Clinical Governance

Evidence review & clinical decisions

Managed Care & Operations

Execution, readiness, & transition

Regulatory Guidance

External compliance guardrails

Policy & Legal Oversight

Internal policy & contract compliance

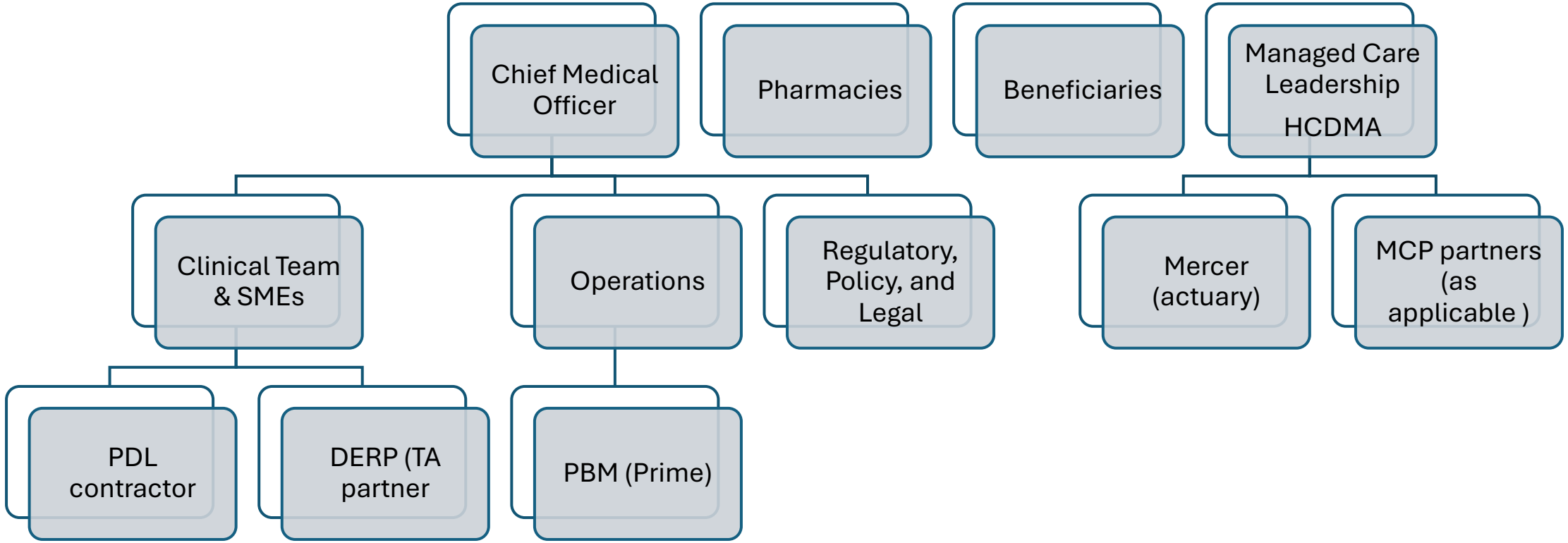
Project Management

Timeline, dependencies & coordination, ongoing monitoring and oversight

Finance

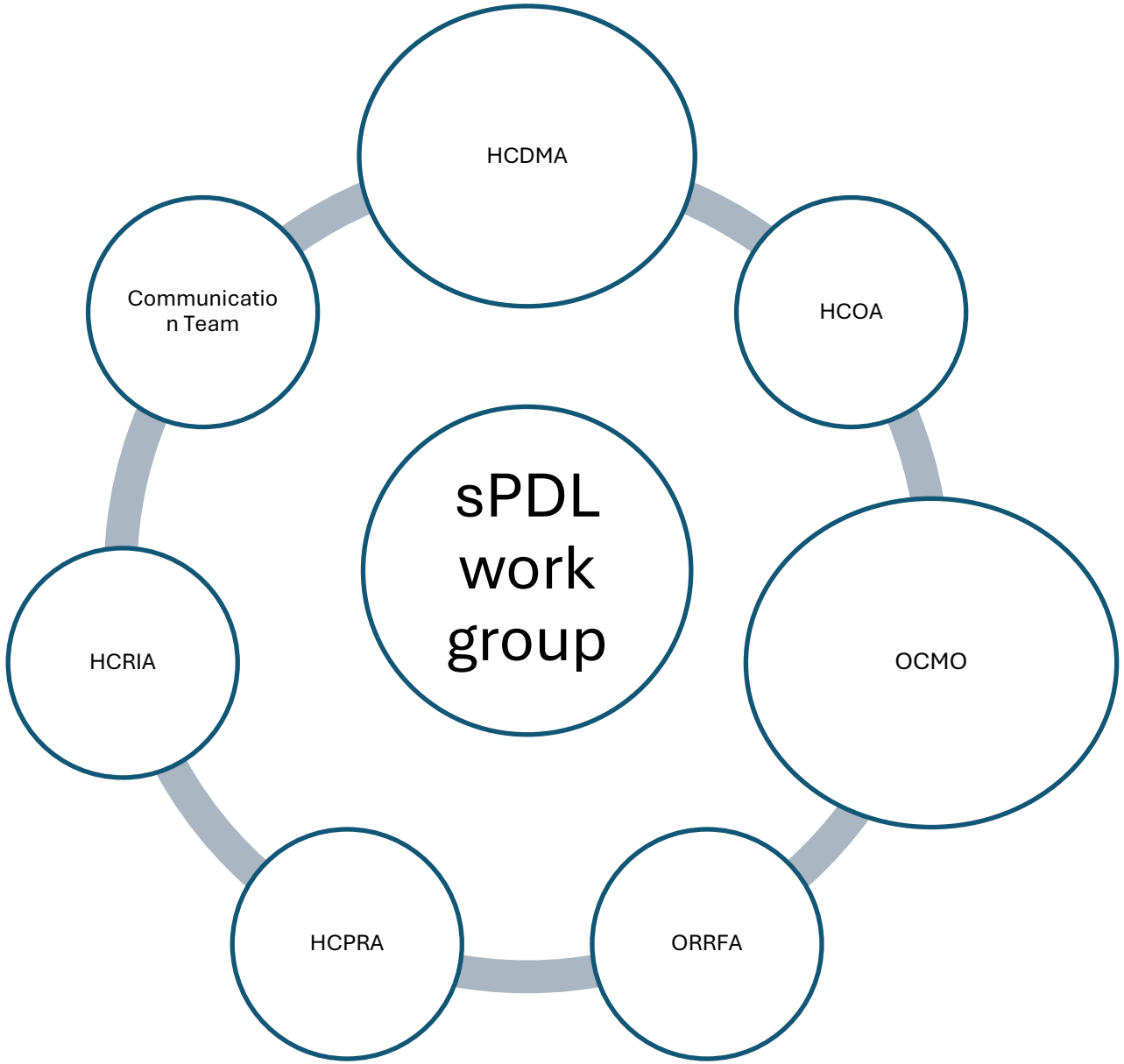
Improve pharmacy spending, optimize rebate opportunities, and support sustainable pharmacy benefit management

DHCF Single Preferred Drug List (sPDL)
Stakeholders



DHCF Single Preferred Drug List (sPDL)

Workgroup needs by Division



Project phases & Key milestones

	Key Milestones/Deliverables
Project Readiness	Approved project governance structure Defined scopes of work for each vendor supporting the project Detailed project plan with accurate timelines
Phase 1: Clinical and Policy Development	Analysis of current PDL structure with identification of high-risk areas and recommendations for changes Completed single PDL and clinical criteria Approved **rollout** policies (grandfathering, Approved **go-forward** policies (P&T committee structure, update cadence, exceptions and appeals
Phase 2: Operational and System Readiness and Communications and Training	Approved process document outlining MCP expectations for sharing materials and supporting go-live Approved contract amendments for MCP contract scheduled Completed testing for data sharing Dashboard framework developed for ongoing DHCF monitoring Approved member notices sent at least 90 days prior to switch Approved communication toolkit with language for use at public forums and in member communication Frequently asked question document Updated webpage with centralized information about the switch to single PDL
Phase 3: Go-Live and Stabilization	Post go-live issue resolution (immediate) Provider communication on authorization switches Implementation of new P&T structure and process Ongoing monitoring of PDL adherence targets

DHCF Single Preferred Drug List (sPDL)
Next Steps

DETERMINE ACTIVITIES IN EACH PHASE

CONFIRM TIMELINES

CONFIRM BUDGET

GET OCP PARTICIPATION FOR CONTRACT NEEDS

MCP UPDATES

March 2026

OPEN DISCUSSION

THANK YOU!

MedStar Family Choice

DISTRICT OF COLUMBIA

It's how we treat people.

DHCF The Department of Health Care Finance INVESTING IN YOUR HEALTH

June 16th & 17th , 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
- **Dr. Mina Tawfeik, PharmD**
- **Mina.Tawfeik@medstar.net**

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

- **Cle'Shawna Bagley, CPhT**
- **Cleshawna.T.Bagley@medstar.net**

Agenda

1. Safety moment
2. Prior Authorization
3. Quick Topics
4. MFC-DC Formulary Changes Effective July 1, 2026
5. POS Beneficiary Notice Forms
6. Provider Issues
7. Questions

Safety Moment: Dexcom G7 Step Therapy & Medication Safety Review

The Prior Authorization (PA) team received a request for a **Dexcom G7 continuous glucose monitor**. As a reminder, the Dexcom G7 is subject to **step therapy**, and our system automatically checks for **anti-diabetic medication fills within the past 6 months** in the enrollee's profile.

If an anti-diabetic medication is found, the claim **adjudicates without requiring a PA**. If **no medication fills** are detected, the claim **triggers a PA** for manual review. During this particular review, the enrollee's medical records showed: **A1C of 10%**, indicating poorly controlled diabetes and active prescriptions for **two types of insulin.** However, when reviewing the claims history, MFC noticed **no anti-diabetic medications had been filled within the past year**. To ensure patient safety, MFC contacted the provider to clarify the discrepancy. The provider was unaware that the prescriptions had **never been received by the pharmacy**. The provider promptly **resubmitted the prescriptions**, and the PA for the Dexcom G7 was approved.

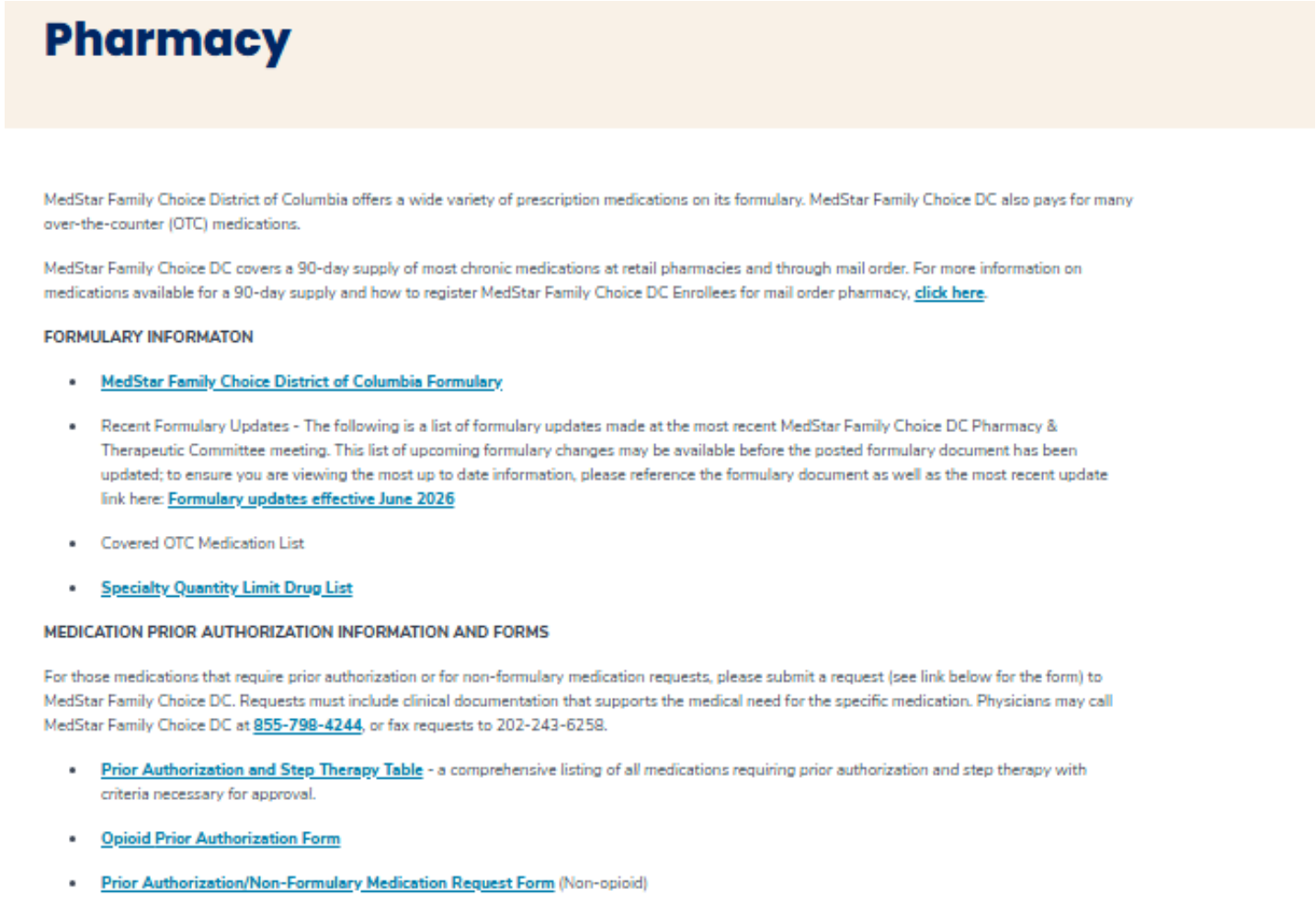
MFC then confirmed that the enrollee **received both her medications and the continuous glucose monitor**, ensuring continuity of care and preventing further gaps in diabetes management.

Prior Authorizations

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: Formulary updates effective June 2026
- 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)

Prior Authorization Process

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

- General PA/NF medications
- Opioids " Submit an opioid form"

✓ Include most recent relevant clinical documentation to support request

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

Prior Authorization and Step Therapy Table

- Provides additional info for Prior Authorizations. To see info, you would go to:

MEDICATION PRIOR AUTHORIZATION INFORMATION AND FORMS

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- Prior Authorization/Non-Formulary Medication Request Form (Non-opioid)

- https://v
- Onc ection:

Prior Authorization and Step Therapy Table

- Then you click on:

MedStar Family Choice DC Prior Authorization and Step Therapy Table

Disclaimer: Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).

Generic Medication (Brand Name) **Bolded** name indicates whether Brand or Generic is Formulary	Approval Criteria & Submission Requirements	Additional Considerations & Renewal Criteria
abaloparatide (**Tymlos**) 3120mcg/1.56ml	1. Prescribed for an approved indication for use: • Treatment of postmenopausal women with osteoporosis at high risk for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy. • Treatment to increase bone density in men with osteoporosis at high risk for fracture, or patients who have failed or intolerant to other available osteoporosis therapy. 2. Patient has diagnosis of post-menopausal osteoporosis and is at high risk for bone fracture. 3. Patient is female, age ≥ 18 years of age. 4. Patient does not have increased baseline risk for osteosarcoma (e.g., Paget's disease of the bone, bone metastases, or skeletal malignancies). 5. T-score ≤ -2.5 based on BMD measurements from the lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) **OR** • History of one of the following resulting from minimal trauma: vertebral compression fracture, fracture of the hip, fracture of the distal radius, fracture of the pelvis, fracture of the proximal humerus. 6. If the criteria in #2 are not met, approval may be granted for patients with both of the following:	1. Treatment duration has not exceeded a total of 24 months of cumulative use of parathyroid hormone analogs (e.g., Teriparatide, Forteo, Tymlos) during the patient's lifetime. 2. Up to 12 months, not intended to last longer than the final infusion completing 24 months of therapy.

Updated: June 2026

Page 1 of 188

- Once you click on link it will show y
and also Additional Consideration &

Formulary

- When looking at formulary it also provides

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

ns

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

Quick Topics

RX Processing Reminders

- Formulary preferred insulins :
  - Long-acting glargine – BRAND Lantus
  - 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

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.

Drug Formulary Changes

Formulary Changes

Effective Date: July 1, 2026

REMOVAL

Medication Impacted	Decision Details
Qulipta	Removed from formulary; added Aimovig, Ajovy
Trelegy	Removed from formulary; Multiple options already exist for treating of COPD such as: Budesonide-formoterol fumarate dihydrate inhalation, COMBIVENT, DULERA, fluticasone furoate-vilanterol aero powder, umeclidinium-vilanterol aero powder and others.

Formulary Changes

Effective Date: July 1, 2026

Prostate Cancer Therapies — Xtandi (enzalutamide) & Nubeqa (darolutamide)

Medication Impacted	Decision Details
Xtandi (enzalutamide)	**New prior authorization (PA) criteria established**. Approved for mCRPC, nmCRPC, mCSPC, and nmCSPC with biochemical recurrence (PSA doubling time ≤9 months). Requires prior abiraterone trial for mCRPC/high-risk mCSPC. Must be used with GnRH agonist/antagonist or post-bilateral orchiectomy. Prescriber must be Oncologist or Urologist. Authorization period: 12 months.
Nubeqa (darolutamide)	**New PA criteria established**. Approved for nmCRPC and mCSPC (with or without docetaxel). Requires prior abiraterone trial for mCSPC. Must be used with GnRH agonist/antagonist or post-bilateral orchiectomy. Prescriber must be Oncologist or Urologist. Authorization period: 12 months.

Formulary Changes

Effective Date: July 1, 2026

Diabetes / Cardiorenal — Jardiance (empagliflozin)

Medication Impacted	Decision Details
Jardiance (empagliflozin) Type 2 Diabetes Mellitus	**New PA criteria established**. Patients ≥10 years with T2DM diagnosis; used with diet and exercise. Step therapy requires trial, intolerance, or documented reason not to use dapagliflozin. Not recommended for glycemic control if eGFR <30 mL/min/1.73m^2. Not approved for Type 1 diabetes or active DKA. Authorization period: 12 months.
Jardiance (empagliflozin) Heart Failure	**New PA criteria established**. Patients ≥18 years with Heart Failure. Step therapy requires trial, intolerance, or documented reason not to use dapagliflozin. May be used if eGFR ≥20 mL/min/1.73m^2. Authorization period: 12 months.
Jardiance (empagliflozin) Chronic Kidney Disease	**New PA criteria established**. Patients ≥18 years with CKD at risk of progression. Step therapy requires trial, intolerance, or documented reason not to use dapagliflozin. May be used if eGFR ≥20 mL/min/1.73m^2. Authorization period: 12 months.

Approved at Ad-Hoc P&T Meeting | April 10, 2026

Formulary Changes

Effective Date: July 1, 2026

Multiple Sclerosis — Kesimpta (ofatumumab)

Medication Impacted	Decision Details
Kesimpta (ofatumumab) Initial Authorization	**Added to the formulary with PA criteria established** for relapsing forms of MS (CIS, RRMS, active SPMS). Patients ≥18 years. Requires trial and failure, intolerance, or contraindication to TWO preferred DMTs (interferon beta products, dimethyl fumarate, glatiramer acetate, or fingolimod). Diagnosis confirmed by clinical evaluation and/or MRI. Prescriber must be or consult with a neurologist. Hepatitis B screening required prior to initiation. No active infection at initiation. Must not be used with another DMT. Authorization period: 12 months.
Kesimpta (ofatumumab) Reauthorization	**Added to the formulary with PA criteria established**. Requires objective clinical response (MRI stabilization, stable/improved EDSS, NEDA achievement, reduced relapses, improved functional scores, or attenuated brain volume loss) OR symptom stabilization/improvement in motor, fatigue, vision, bowel/bladder, spasticity, gait, or sensory function. Authorization period: 12 months.

Formulary Changes

Effective Date: July 1, 2026

Migraine Prevention | Aimovig (erenumab) & Ajovy (fremanezumab)

Medication Impacted	Decision Details
Aimovig (erenumab) **Adults — Migraine Prevention**	**Added to the formulary with PA criteria established**. Diagnosis of migraine per ICHD-3. Patient age per FDA approval. Migraine frequency: 4–7 days/month (<15 headache days) OR ≥8 migraine days/month. Requires inadequate response, intolerance, or contraindication to ≥2 preventive therapies (min. 2-month trial) from: beta-blockers, candesartan, divalproex sodium, Botox, SNRIs, topiramate, or TCAs. Must not be used concurrently with another CGRP agent for prevention. Authorization period: 12 months.
Ajovy (fremanezumab) **Adults — Migraine Prevention**	**Added to the formulary with PA criteria established**. Same adult criteria as Aimovig: ICHD-3 migraine diagnosis, age per FDA approval, migraine frequency threshold met, and inadequate response/intolerance/ contraindication to ≥2 preventive therapies (min. 2-month trial). Must not be used concurrently with another CGRP agent for prevention. Authorization period: 12 months.
Ajovy (fremanezumab) **Pediatric — Ages 6–17 (≥45 kg)** **Episodic Migraine**	**Added to the formulary with PA criteria**; **NEW pediatric indication added**. Patient ages 6–17 years weighing ≥45 kg. Diagnosis of episodic migraine per ICHD-3. Migraine frequency: 4–7 days/month (<15 headache days) OR ≥8 migraine days/month. Requires inadequate response, intolerance, or contraindication to ≥1 preventive therapy (min. 2-month trial) from: topiramate, amitriptyline, or propranolol. Must not be used concurrently with another CGRP agent for prevention. Authorization period: 12 months.

Formulary Changes

Effective Date: July 1, 2026

Migraine Prevention & Cluster Headache — Emgality (galcanezumab)

Medication Impacted	Decision Details
Emgality (galcanezumab) 120 mg Adults — Migraine Prevention	**New PA criteria established**. Diagnosis of migraine per ICHD-3. Patient age per FDA approval. Migraine frequency: 4–7 days/month (<15 headache days) OR ≥8 migraine days/month. Requires inadequate response, intolerance, or contraindication to ≥2 preventive therapies (min. 2-month trial) from: beta-blockers, candesartan, divalproex sodium, Botox, SNRIs, topiramate, or TCAs. Must not be used concurrently with another CGRP agent for prevention. Authorization period: 12 months.
Emgality (galcanezumab) 100 mg Episodic Cluster Headache	**New PA criteria established**. Diagnosis of episodic cluster headache. Age per FDA approval. ≥2 cluster periods (7–365 days) separated by ≥3 pain-free months. Inadequate response, intolerance, or contraindication to ≥1 prophylactic therapy (verapamil, lithium, corticosteroids, or topiramate). Must not be used concurrently with another CGRP agent. Authorization period: 12 months.

POS Beneficiary Notice Forms

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

POS Beneficiary Notice Forms Rem

- 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.*

Provider Resources

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	(202)451-6646

CVSHealth

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

MFC-District of Columbia Office Information

- **MedStar Family Choice – DC Office:**
- 2233 Wisconsin Ave, NW
- 5th floor
- Washington, DC 20007
- (855) 798-4244
- www.medstarfamilychoicedc.com
- Hours of Operation: 8:00AM – 5:30PM (Monday – Friday)


THANK YOU
PHARMACISTS AND STAFF

Questions?

Quarterly Pharmacy Provider Forum

Wellpoint District of Columbia

June 16-17, 2026

Justin Ortique, PharmD

Agenda

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

Key Formulary Changes

EFFECTIVE FOR ALL PATIENTS ON AUGUST 1, 2026			
Therapeutic class	**Drug**	**Revised status**	**Potential alternatives**
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	DALIRESP 250MG, 500MG TABLET	PREFERRED	N/A
ANTI-CATAPLECTIC AGENTS	SODIUM OXYBATE 500MG/ML SOLUTION	PREFERRED WITH ST	
ANTIHYPERTENSIVES	CLONIDINE 0.05MG TABLET	PREFERRED	N/A
ANTINEOPLASTIC ANTIBIOTICS	DOXORUBICIN 2MG/ML, 10MG, 10MG/5ML, 20MG/10ML, 50MG, 50MG/25ML, 200MG/100ML INJECTION	COVERED	N/A
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	VINORELBINE 10MG/ML, 50MG/5ML INJECTION	PREFERRED	N/A
HEMATOPOIETIC AGENTS	NEULASTA 4/0.4ML INJECTION	PREFERRED WITH PA	N/A
MEDICAL DEVICES AND SUPPLIES	TWIIST INSULIN INFUSION DISPOSABLE PUMP	PREFERRED	N/A
MEDICAL DEVICES AND SUPPLIES*	HAN-EASE INJECTION DEVICE	PREFERRED	N/A
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	ETODOLAC 200MG CAPSULE	PREFERRED	N/A
OPHTHALMIC AGENTS	BIMATOPROST 0.01% OPTHALMIC SOLUTION	PREFERRED	N/A
OPIOID ANTAGONISTS*	REZENOPY 10MG NASAL SPRAY	PREFERRED	N/A
SINUS NODE INHIBITORS	CORLANOR 5MG, 7.5MG TABLET CORLANOR 5MG/5ML ORAL SOLUTION	PREFERRED	N/A
SULFONYLUREAS	GLIMEPIRIDE 3MG TABLET	PREFERRED	N/A

Key Utilization Management Changes

UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN AUGUST 1, 2026 *NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY*		
ALTERNATIVE MEDICINES	CRANBERRY 400 MG, 500 MG CAPSULE	REMOVE QL ~~4 CAPSULES PER DAY~~
ANTIANXIETY AGENTS	DIAZEPAM 5 MG/5 ML ORAL SOLUTION	ADD QL 8 ML PER DAY
ANTIANXIETY AGENTS	LORAZEPAM 2 MG/ML INJECTION	ADD QL 10 SYRINGES PER 30 DAYS
ANTIANXIETY AGENTS	LOREEV XR 1MG, 1.5MG, 2MG, 3MG, CAPSULE	REMOVE PA
ANTIASTHMATIC MONOCLONAL ANTIBODIES**	OMLYCLO 300 MG/2 ML PREFILLED SYRINGE	ADD QL 2 PREFILLED SYRINGES PER 28 DAYS
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	BRAND ARNUITY ELLIPTA 50MCG, 100MCG, 200MCG INHALER BRAND ANORO ELLIPTA 62.5MCG-25MCG INHALER	ADD ST
ANTIBIOTIC-ORAL	NUZOLVENCE 3GM ORAL SUSPENSION	ADD PA AND QL 1 KIT (3 GM) PER FILL; 1 FILL PER 30 DAYS
ANTICONVULSANTS	MIDAZOLAM 10 MG/0.7 ML AUTO-INJECTOR	ADD QL 10 AUTO-INJECTORS PER 30 DAYS
ANTICONVULSANTS - MISC.	SUBVENITE 10MG/ML SUSPENSION	ADD PA
ANTIDEPRESSANTS	EXXUA 18.2MG TITRATION PACK	ADD QL 1 PACK, ONE TIME FILL
ANTIDIARRHEAL AGENTS	PEPTO-BISMOL 262 MG/15 ML SUSPENSION	REMOVE QL ~~240 ML PER 90 DAYS~~
ANTIEMETICS**	NEREUS 85 MG CAPSULES	ADD PA AND QL 16 CAPSULES PER FILL, 4 FILLS PER YEAR
ANTIFUNGALS-MISCELLANEOUS**	CLOTIC 1% OTIC SOLUTION	ADD ST
ANTIHYPERLIPIDEMICS	LEROCHOL 300 MG/1.2 ML PREFILLED SYRINGE	ADD PA AND QL 1 SYRINGE PER 28 DAYS
ANTI-INFECTIVE AGENTS - MISC.	VANCOCIN 125MG CAPSULES	UPDATE QL ~~240~~ 120 CAPSULES PER 30 DAYS
ANTINEOPLASTIC ANTIBIOTICS	DOXORUBICIN 2MG/ML, 10MG, 10MG/5ML, 20MG/10ML, 50MG, 50MG/25ML, 200MG/100ML INJECTION	REMOVE PA
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS-TOPICAL	GENERIC CARAC 0.5% CREAM	ADD ST

Key Utilization Management Changes

UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN AUGUST 1, 2026 *NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY*		
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	LUNSUMIO 1MG/ML, 30MG/30ML INJECTION AND LUNSUMIO VELO 5MG/0.5ML, 45MG/ML INJECTION	ADD PA
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	RYBREVANT 350MG/7ML SOLUTION AND RYBREVANT FASPRO INJECTION	ADD PA
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	JOBEVNE 100 MG, 400 MG VIAL INJECTION	ADD PA AND DOSING LIMIT 1.25 MG PER EYE; EACH EYE MAY BE TREATED AS FREQUENTLY AS EVERY 4 WEEKS
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	VYKOURA 50MG/5ML; 350MG/35ML, 500MG/50ML INJECTION	ADD PA
ANTIPSYCHOTICS/ANTIMANIC AGENTS**	VRAYLAR 1.5 MG AND 3 MG BLISTER PACK FANAPT TITRATION PACK A, B, C	UPDATE QL 1 PACK ~~PER YEAR~~, ONE TIME FILL
ANTIPSYCHOTICS/ANTIMANIC AGENTS	VRAYLAR CAPSULE 0.5 MG VRAYLAR CAPSULE 0.75 MG	ADD QL 1 CAPSULE PER DAY
ANTIPSYCHOTICS/ANTIMANIC AGENTS	BYSANTI 1MG TABLET BYSANTI 2MG TABLET BYSANTI 4MG TABLET BYSANTI 6MG TABLET BYSANTI 8MG TABLET BYSANTI 10MG TABLET BYSANTI 12MG TABLET	ADD PA AND QL 2 TABLETS PER DAY
ANTIPSYCHOTICS/ANTIMANIC AGENTS	BYSANTI TITRATION PACK A, B, C	ADD QL 1 PACK, ONE TIME FILL
BETA BLOCKERS	METOPROLOL TARTRATE 12.5MG TABLET	ADD ST
BONE DENSITY REGULATORS	BONCRESA 60 MG/ML PREFILLED SYRINGE	ADD PA AND QL 60 MG (1 PREFILLED SYRINGE) EVERY 6 MONTHS
BONE DENSITY REGULATORS	OZILTUS 120 MG/1.7 ML VIAL SOLUTION	ADD PA AND QL 1 VIAL PER 28 DAYS
CALCIUM CHANNEL BLOCKERS	CARDAMYST 70 MG NASAL SPRAY	ADD PA AND QL 2 NASAL SPRAYS (1 CARTON) PER FILL, 6 FILLS PER YEAR

Key Utilization Management Changes

UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN AUGUST 1, 2026 *NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY*		
CARDIOVASCULAR AGENTS - MISC.	TYVASO DPI INHALATION POWDER 112 32 MCG MAINTENANCE KIT (CARTRIDGES, 112 64 MCG CARTRIDGES) TYVASO DPI INHALATION POWDER MAINTENANCE KIT (112 48 MCG CARTRIDGES, 112 64 MCG CARTRIDGES)	ADD QL 1 KIT PER 28 DAYS
CARDIOVASCULAR AGENTS - MISC.	MYQORZO 5MG TABLET MYQORZO 10MG TABLET MYQORZO 15MG TABLET MYQORZO 20MG TABLET	ADD PA AND QL 1 TABLET PER DAY
CENTRAL MUSCLE RELAXANTS	ONTRALFY 2 MG/5 ML SOLUTION	ADD ST AND QL 90 ML PER DAY
COUGH/COLD/ALLERGY	PHENYLEPHRINE/CHLORPHENIRAMINE/DEXTROMETHORPHAN LIQUID (NEOTUSS PLUS) DESLORATADINE-PSEUDOPHEDRINE 2.5-120 (CLARINEX-D 12 HOUR) CHLOPHEDIANOL COMBINATION (ALL FORMULATIONS)	ADD AGE EDIT MINIMUM AGE OF 2 YEARS OLD
DERMATOLOGICALS**	ADQUEY 1% OINTMENT	ADD PA AND QL 85 GRAMS PER 30 DAYS
DERMATOLOGICALS	EUCERIN CREME	REMOVE QL ~~480 GM PER 30 DAYS~~
DERMATOLOGICALS	EUCERIN LOTION	REMOVE QL ~~480 ML PER 30 DAYS~~
ELECTROLYTES ORAL	PEDIALYTE SOLUTION	REMOVE QL ~~6000 ML PER 30 DAYS~~
ENDOCRINE AND METABOLIC AGENTS - MISC.	LOARGYS 2 MG/0.4 ML, 5 MG/ML VIAL	ADD PA AND DOSING LIMIT 0.2 MG/KG ONCE WEEKLY
ENDOCRINE AND METABOLIC AGENTS - MISC.	YUVIWEL 1.3 MG INJECTION SINGLE-DOSE VIAL YUVIWEL 2.8 MG INJECTION SINGLE-DOSE VIAL YUVIWEL 5.5 MG INJECTION SINGLE-DOSE VIAL	ADD PA AND QL 4 KITS (4 VIALS) PER 28 DAYS
ENDOCRINE AND METABOLIC AGENTS - MISC.	MYCAPSSA DELAYED-RELEASE 20MG CAPSULES	UPDATE QL ~~1 BLISTER PACK PER 7 DAYS (4 BLISTER PACKS PER 28 DAYS)~~ 4 CAPSULES PER DAY
GASTROINTESTINAL AGENTS - MISC.	REBYOTA 1:50ML RECTAL SUSPENSION	UPDATE QL ONE 150 ML DOSE PER FILL; ONE ~~TIME~~ FILL PER YEAR

Key Utilization Management Changes

UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN AUGUST 1, 2026 *NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY*		
GASTROINTESTINAL AGENTS - MISC.	VOWST CAPSULE	UPDATE QL ONE 12 CAPSULES PER FILL; ONE ~~TIME ONLY~~ FILL PER YEAR
GROWTH HORMONES	ZOMACTON 5MG INJECTION VIAL	UPDATE QL ~~1~~ 2 VIALS PER DAY
HEMATOLOGICAL AGENTS - MISC	WAYRILZ 400MG TABLET	ADD ST
HEMATOLOGICAL AGENTS - MISC	ORLADEYO PACK 72 MG PELLETS ORLADEYO PACK 96 MG PELLETS ORLADEYO PACK 108 MG PELLETS ORLADEYO PACK 132 MG PELLETS	ADD PA AND QL 1 PELLET/PACKET PER DAY
HEMATOLOGICAL AGENTS - MISC	AQVESME 100MG TABLET	ADD PA AND QL 2 TABLETS PER DAY
HEMATOLOGICAL AGENTS - MISC	YARTEMLEA 370MG/2ML INJECTION	ADD PA
HEMATOLOGICAL AGENTS - MISC.	FESILTY INJECTION	ADD PA
HEMATOPOIETIC AGENTS	IRON 325MG TABLET FERROUS SULFATE 324MG TABLET EC	REMOVE QL ~~3 TABLETS PER DAY~~
IRON	FERAHEME 510MG/17ML INJECTION VIAL*	REMOVE PA ~~1020 MG PER 6 DAYS~~
IRON	FERRLECIT 62.5 MG/5 ML INJECTION VIAL*	REMOVE PA ~~1000 MG PER 8 WEEKS~~
IRON	VENOFER 50 MG/2.5 ML VIAL*,100 MG/5 ML VIAL*, 200 MG/10 ML INJECTION VIAL*	REMOVE PA AND QL ~~1000 MG PER 14 DAYS~~
IRON	INFED 50MG/ML INJECTION	REMOVE PA
IRON	INJECTAFER 100MG/2ML VIAL*, 750 MG/15 ML VIAL*, 1000 MG/20 ML INJECTION VIAL*	REMOVE PA AND QL ~~1500 MG PER 7 DAYS~~
IRON	MONOFERRIC 100 MG/ML VIAL*, 500 MG/5 ML VIAL*, 1000 MG/10 ML INJECTION VIAL*	REMOVE PA AND QL ~~1000 MG PER DAY~~
LAXATIVES	COLACE 50MG CAPSULE	REMOVE QL ~~6 CAPSULES PER DAY~~
LAXATIVES	COLACE 100MG T CAPSULE/TABLET	REMOVE QL ~~3 CAPSULES/TABLETS PER DAY~~
LAXATIVES	FIBERCON 625MG TABLET	REMOVE QL ~~4 TABLETS PER DAY~~

Key Utilization Management Changes

UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN AUGUST 1, 2026 *NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY*		
MINERALS & ELECTROLYTES	ZYCUBO 2.9 MG INJECTION SINGLE-DOSE VIAL	ADD PA AND QL 1 VIAL PER DAY
MISC. NUTRITIONAL SUBSTANCES	ALGAL-900 DHA 300MG CAPSULE	REMOVE QL ~~1 CAPSULE PER DAY~~
MULTIPLE VITAMINS W/ MINERALS	DIABETIC MULTIVITAMIN	REMOVE QL ~~1 TABLET PER DAY~~
NASAL AGENTS-MISC.	AYR SALINE 0.65% SPRAY DROPS	REMOVE QL ~~2 FILLS PER DAY~~
NASAL AGENTS-MISC.	NASADROPS 0.9% NASAL SOLUTION AMPULES	REMOVE QL ~~2 FILLS PER 30 DAYS~~
NASAL AGENTS-MISC.	OCEAN 0.65% NASAL SPRAY	REMOVE QL ~~50 ML PER 90 DAYS, 2 FILLS PER 30 DAYS~~
NEUROMUSCULAR AGENTS	DAYBUE 200MG/ML SOLUTION DAYBUE STIX POWDER PACKET	ADD PA
NEUROMUSCULAR AGENTS	DAYBUE STIX 5,000MG PACKET DAYBUE STIX 6,000MG PACKET	ADD QL 4 PACKETS PER DAY
NEUROMUSCULAR AGENTS	DAYBUE STIX 8,000MG PACKET	ADD QL 2 PACKETS PER DAY
OPHTHALMIC AGENTS**	NUFYMCO 0.3 MG, 0.5MG INJECTION VIAL	ADD ST AND NEW DOSING LIMITS **DIABETIC MACULAR EDEMA AND DIABETIC RETINOPATHY**: 0.3 MG PER EYE; EACH EYE MAY BE TREATED AS FREQUENTLY AS EVERY 4 WEEKS. **AGE RELATED MACULAR DEGENERATION, BRANCH OR CENTRAL RETINAL VEIN OCCLUSION, MYOPIC CHOROIDAL NEOVASCULARIZATION, AND RADIATION RETINOPATHY**: 0.5 MG PER EYE; EACH EYE MAY BE TREATED AS FREQUENTLY AS EVERY 4 WEEKS
OPHTHALMIC AGENTS	YUVEZZI 2.75%/0.1%OPHTHALMIC SOLUTION	ADD PA AND QL 1 VIAL PER DAY
OPHTHALMIC AGENTS	QLOSI 0.4% OPHTHALMIC SOLUTION	UPDATE QL ~~60~~ 2 VIALS PER ~~30~~ DAY~~S~~
OTIC AGENTS	CIPROFLOXACIN-HYDROCORTISONE 0.2-1% OTIC SUSPENSION	ADD ST
POTASSIUM	POTASSIUM GLUCONATE 2.5 MEQ TABLET	REMOVE QL ~~4 TABLETS PER DAY~~
PROBIOTIC AGENTS-MISC.	ACIDOPHILUS PROBIOTIC TABLET/CAPSULE	REMOVE QL ~~4 TABLETS/CAPSULE PER DAY~~
UREA CYCLE DISORDER- AGENTS	GLYCEROL PHENYLNUTYRATE 1.1GM/ML LIQUID	ADD ST
UREA CYCLE DISORDER- AGENTS	OLPRUVA 0.5 GM PACK OLPRUVA 1 GM PACK	ADD QL 1 KIT (90 DOSAGE ENVELOPES) PER 30 DAYS
VAGINAL AND RELATED PRODUCTS	CLOTRIMAZOLE-7 VAGINAL 1% CREAM	REMOVE QL ~~45 GM PER 30 DAYS~~
VAGINAL AND RELATED PRODUCTS	MONISTAT 3 COMBINATION PACK	REMOVE QL ~~1 PACK PER 30 DAYS~~
ZINC	ZINC CHELATE 50 MG TABLET	REMOVE QL ~~4 TABLETS PER DAYS~~

Pharmacy Updates : Recall

- True Metrix Recall
-
  - applies to glucose meters only; test strips are not included
  - Reason for recall: the E-5 error code is used for two different situations
    - Very high blood glucose event (>600 mg/dL)
    - Test strip error
  - Risk/impact: users may misinterpret E-5, potentially leading to serious adverse health consequences
  - Reported outcomes (as of January 16): 114 serious injuries and 1 death reported by Trividia Health
  - FDA recommendation: transition to an alternative blood glucose testing method when possible
  - Patients should continue monitoring and should not stop using the TRUE METRIX meter until an alternative method is available
  - Trividia Health actions: updating labeling and user messaging to reinforce updated E-5 instructions
  - Long-term plan: updated meters and a comprehensive upgrade/replacement program planned; ETA not provided
-

Pharmacy Updates: Accu-Check added to Preferred Drug List

- **Interim PDL Update (TRUE METRIX Recall Response)**
  - In the best interest of our enrollees, the P&T Value Assessment Committee added Accu-Chek products to the Preferred Drug List.
  - Below is the processing information for Meters:

- **Pharmacy Instructions for Meters:**
- Please use a prescription on file or call the patient's physician to obtain a new prescription.
-
- **BIN#:** 610524
- **PCN:** 1016
- **Group #:** 40026479
- **Identification #:** 269489595
- **Issuer #:** (80840)

- For assistance, the pharmacy can call the Accu-Chek Pharmacist Help Line at 1-800-657-7613 (Hours: 8AM – 8PM ET, Monday - Friday). Once a FREE meter is processed for reimbursement, you cannot submit for a claim to any other third-party payer. One meter per patient every 12 months

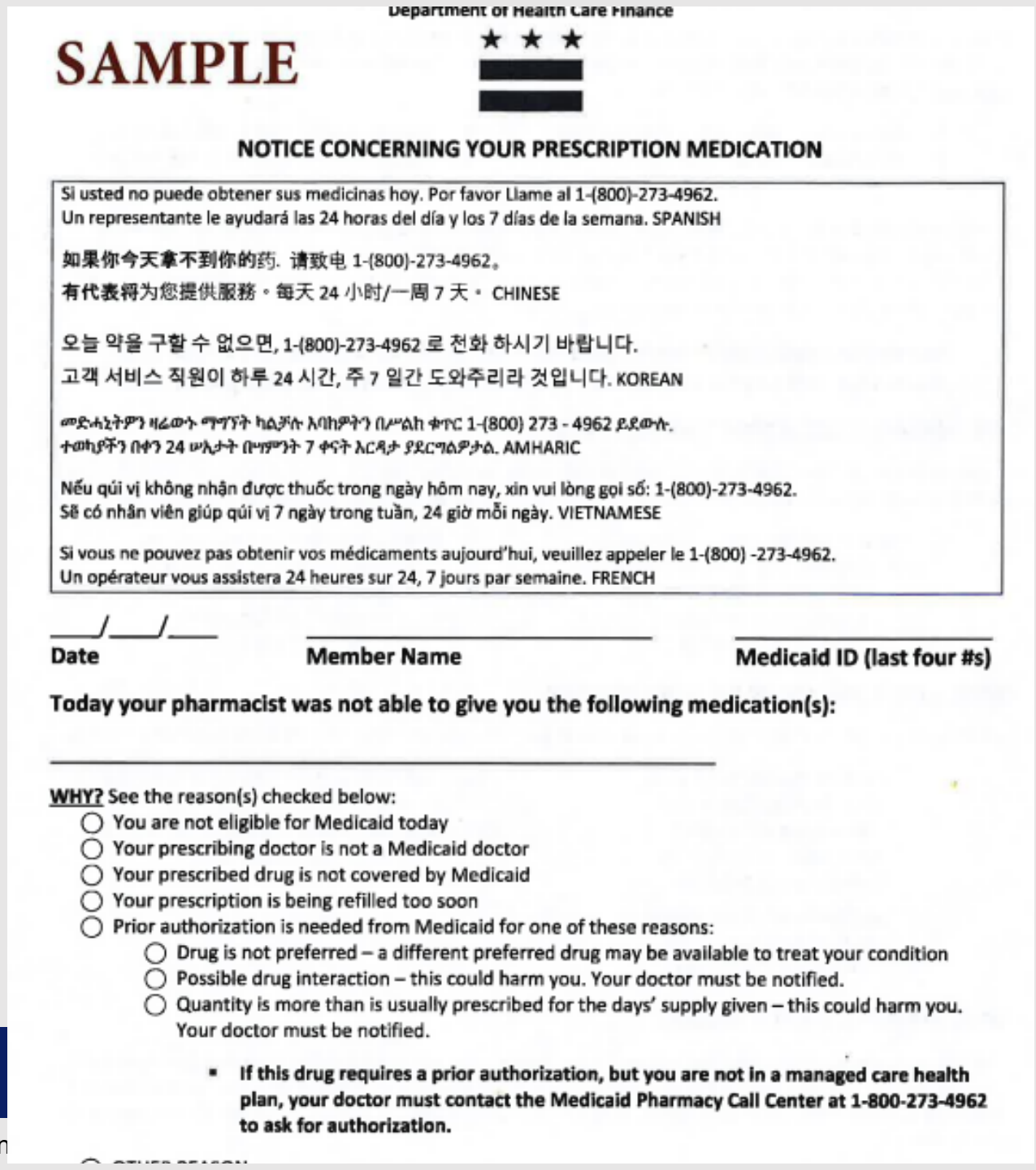
Reminder: Beneficiary Notice Forms

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.
ተወካዮችን 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.**

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]

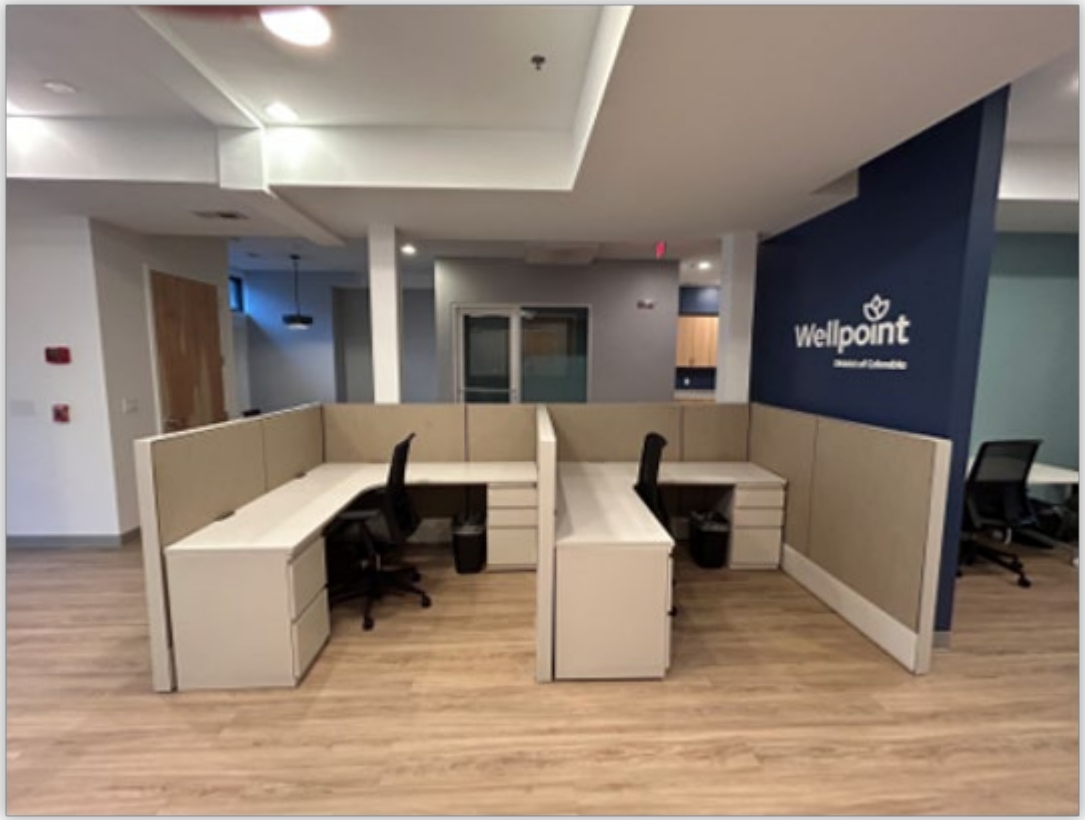
The Sydney Health mobile app makes it easy to find a doctor, access your ID card, and chat with a live representative.

New Wellness Center

❖ **Ward 8 Wellness Center**
1306 Marion Barry Ave SE, Washington, DC 20020

Key Initiatives and Programs

- Enrollee Advisory Committee Meetings
- Face-to-Face meetings with Case Managers
- Onsite renewal assistance
- Member orientation and Value-Added Benefits overview
- Technology training
- Baby showers and diaper distributions
- Quality-based events to close gaps in care
- Nutrition education and cooking demos



Thank you!

Questions?

- Insert appropriate disclosure from the Legal Disclosure Database

- Lorem ipsum dolor sit amet, consectetuer adipiscing elit. Maecenas porttitor congue massa. Fusce posuere, magna sed pulvinar ultricies, purus lectus malesuada libero, sit amet commodo magna eros quis urna. Pellentesque habitant morbi tristique senectus et netus et malesuada fames ac turpis egestas. Proin pharetra nonummy pede. Mauris et orci. Lorem ipsum dolor sit amet, consectetuer adipiscing elit. Maecenas porttitor congue massa. Fusce posuere, magna sed pulvinar ultricies, purus lectus malesuada libero, sit amet commodo magna eros quis urna. Pellentesque habitant morbi tristique senectus et netus et malesuada fames ac turpis egestas. Proin pharetra nonummy pede. Mauris et orci. sit amet commodo magna eros quis urna. Pellentesque habitant morbi tristique senectus et netus et malesuada fames ac turpis egestas. Proin pharetra nonummy pede. Mauris et orci

DHCF Quarterly Pharmacy Forum
June 16-17, 2026

Leslie Addison, Manager Pharmacy Services

HSCSN

Agenda

- Drug Formulary Updates
  - July 1, 2026
- Pharmacy Services Update
  - 90-Day Fill

Drug Formulary Updates

Formulary Additions- Effective- July1, 2026

Drug	Preferred Non-Preferred	Brand Generic	Criteria
Cobenify (xanomeline/ trospium) 100-20mg, 125-30mg, 50mg-20mg, 50-20mg&100mg-20mg pack capsules	Preferred	Brand	PA
Epysqli (eculizumab-AAGH**)** 300mg-30ml for infusion	Preferred	Brand	PA, QL
Exenatide injection pen	Preferred	Generic	ST, QL

* Deletion based on Generic Product Indicator (GPI)

Formulary Deletions – Effective- July 1, 2026

Drug	Brand/Generic
Sandimmune oral solution 100mg/ml	Brand
Soliris 10mg/ml injection for infusion	Brand
Synagis 50mg/ml, 100mg/ml injection	Brand
Amoxicillin-clavulanate 200-28.5mg chewable tablet	Generic
Erythromycin stearate tablet 250mg	Generic

*Deletion based on Generic Product Indicator (GPI)

Upcoming (UM) Changes **Effective-** July 1, 2026

Drug	Brand/Generic	UM Change Removed (Quantity Limit)
Granisetron 1mg tablet	Generic	QL
Ondansetron (oral solution, tablets ODT) 4mg, 8mg, 24mg	Generic	QL

*Deletion based on Generic Product Indicator (GPI)

Access to Drug Formulary

Search the Formulary »

Download the Formulary (Machine Readable) »

Download the Formulary [PDF] »

HSCSN website Pharmacy Benefits

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

90-Day Fill Update

HSCSN 90-Day Prescription Fill Program: Update

- **Go-Live:** May 22, 2026
- **Program:** CVS Caremark Maintenance Choice (90-day supply for maintenance medications)
- **How it works:**
  - Enrollees may fill a 90-day prescription at participating pharmacies
  - Enrollee will need to use CVS Caremark Maintenance Choice network pharmacies

II. HSCSN 90-Day Prescription Fill Program: Update cont.

- **Participating pharmacies (DC):**
  - CVS
  - Costco
  - Harris Teeter
  - If needed other network pharmacies are available outside of District
- **Participation:**
  - It is a voluntary program for HSCSN enrollees
  - A 90-day prescription needs to accompany the request
- **Goal:**
  - To improve medication adherence
  - To increase convenience for enrollees

HSCSN Pharmacy Services
Helpful Information

Pharmacy Services: Retail & Specialty

Retail Pharmacy Services

- Access through CVS/Caremark pharmacy network
- 30-day supply (max 34 days)
- 90-day fills available at participating pharmacies CVS, Costco, Harris Teeter
- No copayments required

Specialty Pharmacy Service

CVS Specialty Pharmacy

Fax: 1-800-323-2445 I **Phone:** 1-866-387-2573

- High-cost medications for complex conditions
- Refill notifications via email, text, or phone
- No co-payments required

Opioid Prior Authorization (PA) Overview

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

- Prior Authorizations are required if any of the following conditions are met:
  -More than 7 days supply for short-acting opioids
  -Use of a long-acting opioids
  -Early refill requests
  -Greater than >90 Morphine Milligram Equivalent (MME) daily
  -More than one opioid in 90 days

- CVS Caremark PA Customer Service
  -Phone: 1-844-449-8734

General Prior Authorization (PA): Submission Options

Prior authorizations are processed through the CVS Caremark Utilization Management team.

✓ **Phone**

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

✓ **Fax (Prescriber)**

- Submit PA form to CVS Caremark 1-888-836-0730
- Form available on the HSCSN website
- Fax requests accept fax 24 hours a day

✓ ***e*PA (Pharmacist/Prescriber)**

- Submit electronically via CoverMyMeds
- https://www.covermymeds.health/prior-authorization-forms/caremark

Contact Information

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

Thank You!

Questions/Comments

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

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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.**

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

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HSCSN Online

hscsnhealthplan.org.
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[illegible] 7:00 [illegible] 5:30 [illegible] 202-467-2737 [illegible] **Amharic.**

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DHCF Department of Health Care Finance

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Achievement Badges

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UnitedHealthcare DC Dual Choice

Nicole L Zvosecz, PharmD

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

Plan Overview 2026

- Mail Order Benefit
- Members have 1 ID card for both Medicare and Medicaid
- Copays based on (LIS) Low-income subsidy
- 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.

2026 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"

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
- Tier 2 to 5 drugs follow the chart below
- Tiering is [illegible]ol

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

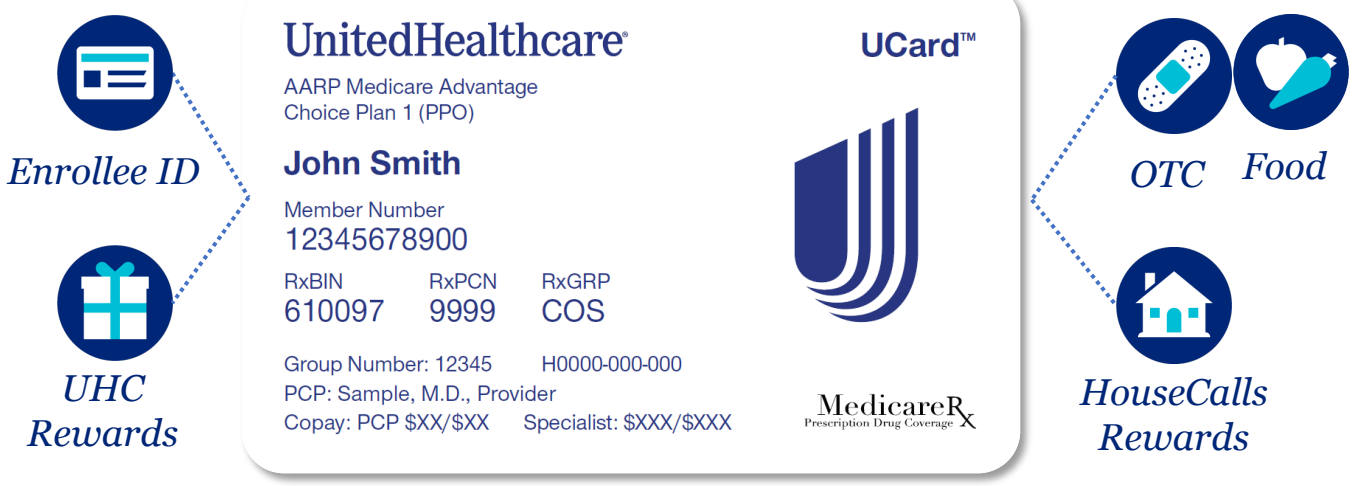
Pharmacy Claims Processing Information

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	$131 per month Over the Counter (OTC), food allowance, and utilities combined credit (expires monthly) UHC Medicaid approved OTC are covered under Pharmacy benefit	$177 per month OTC, food allowance, and utilities combined credit (expires monthly) UHC Medicaid approved OTC are covered under Pharmacy benefit	$88 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

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

Types of Coverage Determinations

Prior Authorization

These drugs are listed on the formulary as requiring a PA

Specific coverage criteria is approved by CMS and posted

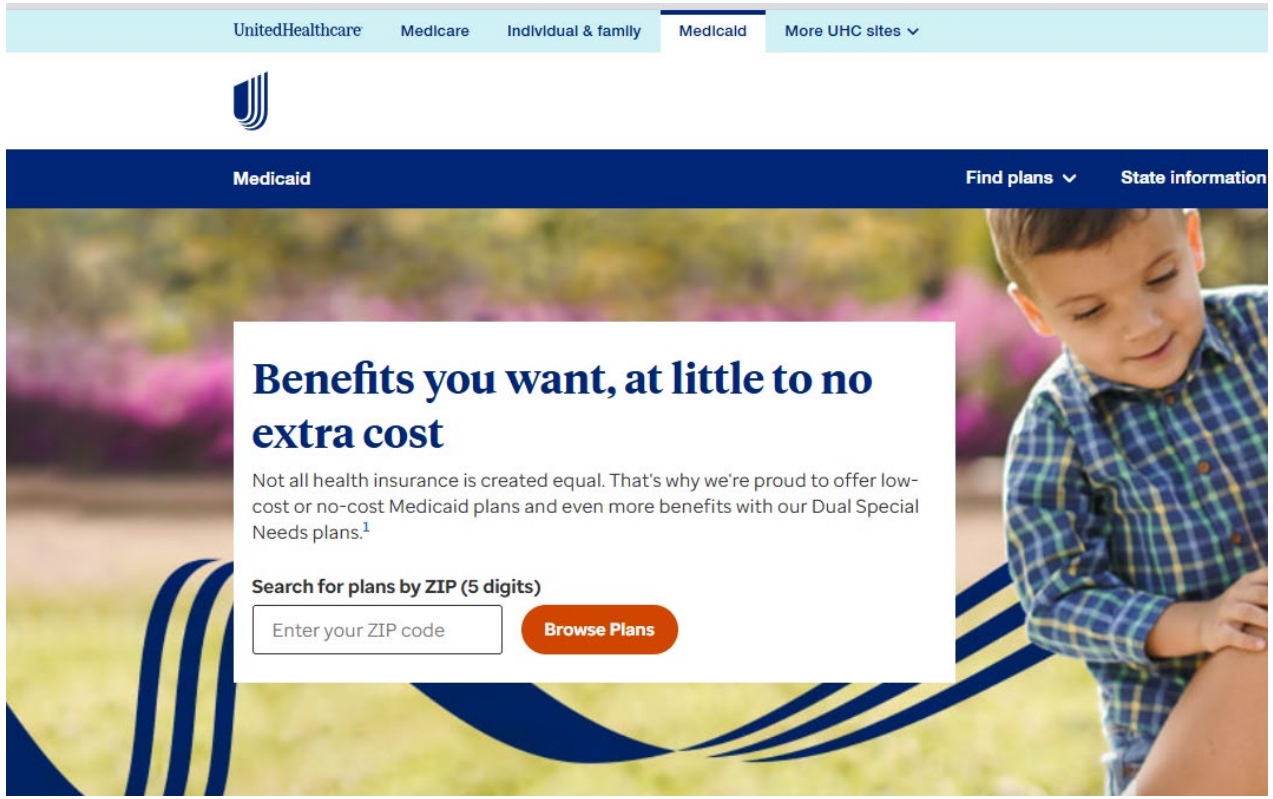
Coverage Exception

These drugs are not listed on the formulary

May be covered by submitting a coverage exception request

Web Tools

Find a Plan Tool

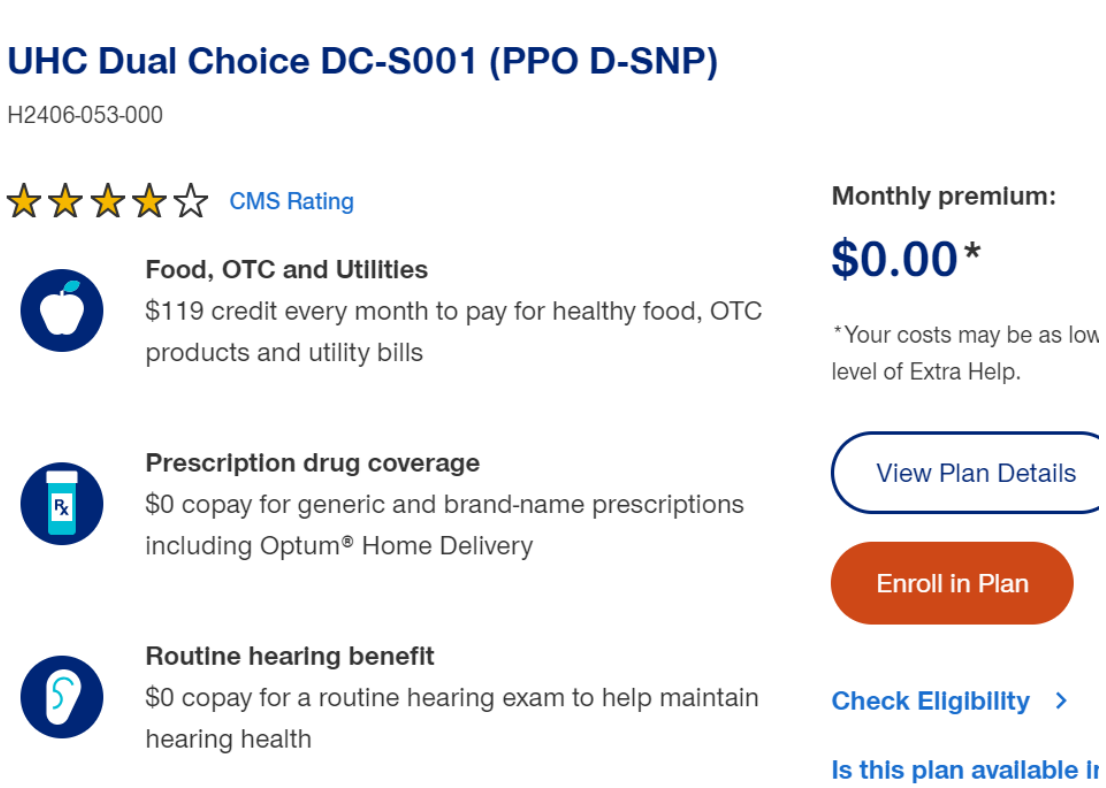


Go to: www.uhccp.com

Enter your zip code and click Browse Plans to view the different plans available in your area.

District of Columbia D-SNP Plans | UnitedHealthcare Community Plan (uhc.com)

Find a Plan



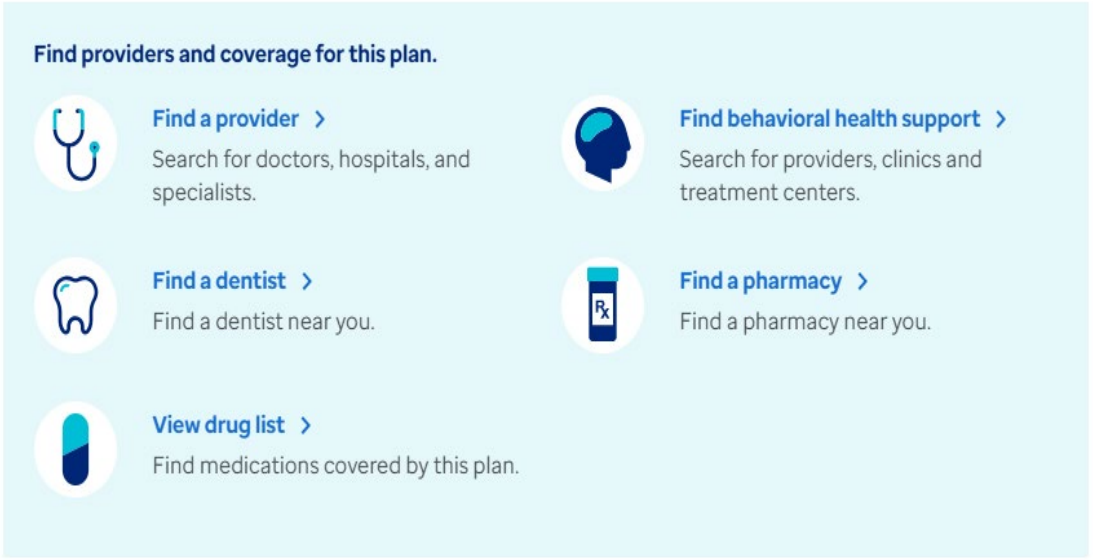
This is how an individual plan preview displays.

There are 3 plans available in DC

Note the STARS rating is listed under the plan name

Click on: View Plan Details to see more in-depth info

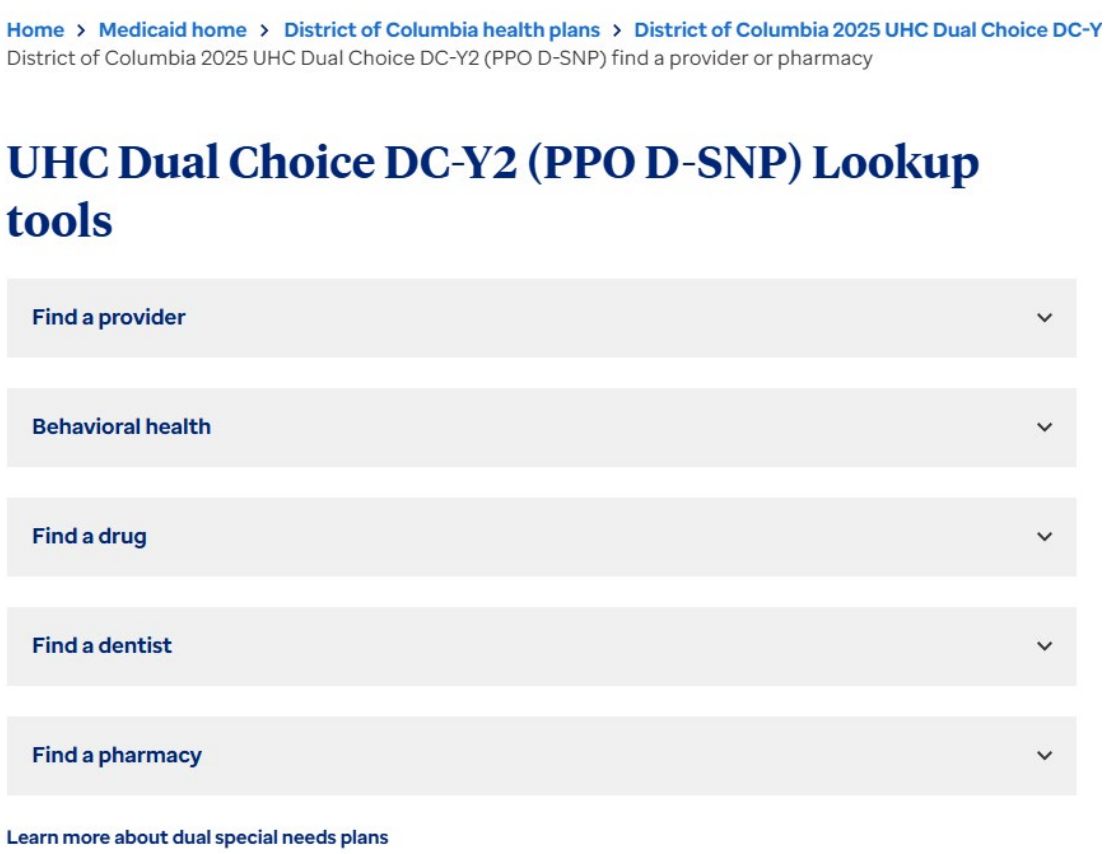
Pharmacy Benefit Information



Scroll down the page halfway to see these options

Both the links to the drug list and network pharmacies are listed in addition to other helpful links

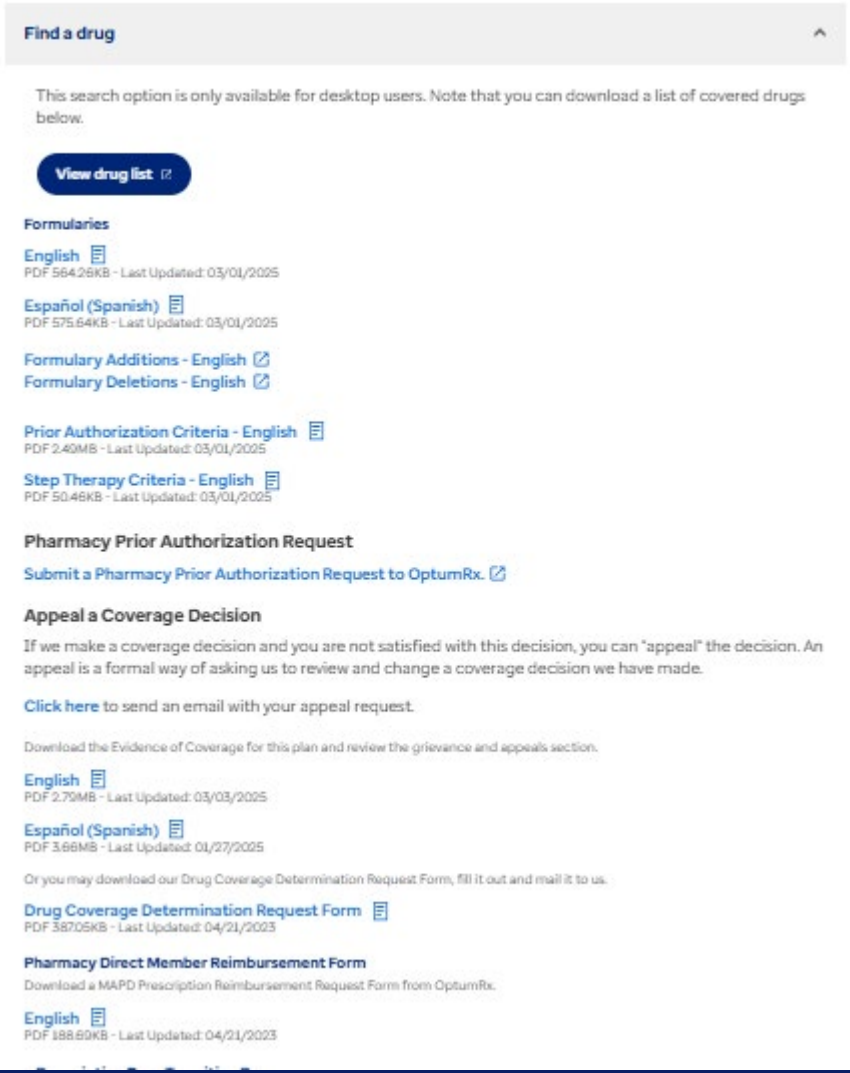
Pharmacy Benefit Information



Clicking on the prior screen brings you here

Click on find a drug to expand the section

Formulary Information



Find a drug

This search option is only available for desktop users. Note that you can download a list of covered drugs below.

View drug list

Formularies

English
PDF 564.26KB - Last Updated: 03/01/2025

Español (Spanish)
PDF 575.64KB - Last Updated: 03/01/2025

Formulary Additions - English
Formulary Deletions - English

Prior Authorization Criteria - English
PDF 2.49MB - Last Updated: 03/01/2025

Step Therapy Criteria - English
PDF 50.46KB - Last Updated: 03/01/2025

Pharmacy Prior Authorization Request

Submit a Pharmacy Prior Authorization Request to OptumRx.

Appeal a Coverage Decision

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

Click here to send an email with your appeal request.

Download the Evidence of Coverage for this plan and review the grievance and appeals section.

English
PDF 2.79MB - Last Updated: 03/03/2025

Español (Spanish)
PDF 3.66MB - Last Updated: 01/27/2025

Or you may download our Drug Coverage Determination Request Form, fill it out and mail it to us.

Drug Coverage Determination Request Form
PDF 387.05KB - Last Updated: 04/21/2023

Pharmacy Direct Member Reimbursement Form

Download a MAPD Prescription Reimbursement Request Form from OptumRx.

English
PDF 188.69KB - Last Updated: 04/21/2023

Now you can see all the formulary tools including

- **Drug look up**
- **Formulary list**
- **PA criteria and Forms**
- **Appeals info**
- **Reimbursement form**

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?

Low-Income Subsidy (LIS)

- LIS is Medicare Part D program that helps people with limited income and resources pay for prescription drug coverage.
- LIS is adjusted through Social Security administration

What Needs to Change	Who Adjusts LIS	How the Member Does It
Income or resources	**SSA**	Update LIS application (online, mail, in-person) [secure.ssa.gov]
Medicaid category (QMB/SLMB/FBDE etc.)	**State Medicaid** (then SSA updates LIS)	Report changes to Medicaid office; redetermination occurs [cms.gov]
Newly applying for LIS	**SSA or State Medicaid**	File LIS application; SHIP can help [medicare.gov]

Pharmacy Provider Forum

Tracey Davis, PharmD

June 2026

February 2026 P&T changes

- The following products will be **added** to the formulary on 7/1/26:

➢ Epinephrine (Epipen Jr®, Epipen®)0.15, 0.3 mg auto-inector
➢ Epinephrine (Adrenaclick®) 0.15, 0.3 mg auto-injector
➢ Shingrix Intramuscular Suspension Prefilled Syringe 50 MCG/0.5ML
➢ Diskets Oral Tablet Soluble 40 MG
➢ Avtozma Subcutaneous Solution Prefilled Syringe 162 MG/0.9ML
➢ Avtozma Subcutaneous Solution Auto-injector 162 MG/0.9ML
➢ Rezenopy Nasal Liquid 10 MG/0.11ML

February Formulary changes

- The following products will be **Age limit changes** to the formulary on 7/1/26:

➢ Various cough and cold products

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

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