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## GHP and Geisinger Gold ranked top in Pennsylvania



For the fourth year in a row, Geisinger Health Plan (GHP) and Geisinger Gold are the top-ranked private and Medicare health plans in Pennsylvania.\* Nationally, GHP's health maintenance organization (HMO) is ranked eighth and Geisinger Gold's HMO is ranked ninth for quality and service by the National Committee for Quality Assurance (NCQA). The 2011-2012 rankings mark the first time that NCQA ranked PPO plans. Geisinger Choice was the second highest ranked plan in Pennsylvania and was ranked No. 17 nationally.

"We have worked hard to ensure that Geisinger Health Plan members receive better care, and these rankings are the result of our hard work. Our ranking is also a reflection of the excellent care all of our providers in our network give to our members," says GHP President and CEO Jean Haynes.

NCQA ranked more than 483 private HMO and PPO plans, and more than 385 HMO and PPO Medicare plans. These lists are the only apples-to-apples comparison of health-care quality and customer satisfaction in the nation.

Duane Davis, M.D., GHP vice president and chief medical officer, says, "High rankings such as those received by GHP send a message that our members ultimately receive better care. We have developed ways to ensure children see their doctors and receive important immunizations, and that adults remain on medications that prevent future heart attacks. We recognize how important it is to reach out to women to help them schedule screenings that detect breast and cervical cancer early. Our members want the best for their loved ones, and we work hard to deliver it."

\*NCQA's Private Health Insurance Plan Rankings 2011-2012 and NCQA's Medicare Health Insurance Plan Rankings 2011-2012. *U.S. News/NCQA America's Best Health Insurance Plans 2007-2009 (annual)*. "America's Best Health Insurance Plans" is a trademark of *U.S. News & World Report*.

## Health management and wellness

GHP's health management and wellness programs help our members manage specific chronic health conditions. Health managers will work with you and your patients to help them better manage their health-care needs. This includes education on diet, exercise, medications and other lifestyle changes.

Programs offered: asthma, chronic obstructive pulmonary disease (COPD), tobacco cessation, diabetes, osteoporosis, hypertension, heart failure, heart disease and weight management.

For more information, or to recommend a member for one of these programs, please call (800) 883-6355.

### Hypertension

We will teach members how to control and monitor blood pressure, as well as setting individual goals to help reduce the risk of developing other related health problems.



## Renal protection for diabetics

Diabetes mellitus and hypertension are the leading causes of chronic kidney disease for patients in the United States. Most diabetics are also hypertensive, and kidney damage stands to be a major complication, due to progression of these diseases. Antihypertensive agents from the ACE inhibitor class and the ARBs have been shown to provide renoprotection to patients at risk for kidney disease. They also slow progression to end stage renal disease (ESRD) in patients already afflicted, whether or not hypertension is a contributor. Current guidelines recommend the use of Renin-Angiotensin-Aldosterone system (RAAS) inhibitors in all stages of chronic kidney disease, regardless of progression. RAAS inhibitors may even slow the decline of renal function in patients already undergoing dialysis with end stage kidney disease. Though RAAS inhibitors can potentially cause a worsening of renal function and/or hyperkalemia, discontinuing the medications indefinitely -- due to an acute, reversible episode of kidney injury -- is NOT advised.

Although a temporary withholding of medication may be necessary, therapy re-challenge with a lower dose, after resolution of the acute injury, should be considered. Consider prescribing an ACE inhibitor or an ARB first to ALL diabetes patients with microalbuminuria, to slow the rate of proteinuria, especially in the presence of hypertension. Consider prescribing an ARB as first-line therapy for all type-II patients who have already progressed to macroalbuminuria.

The following are recommendations from the American Diabetes Association:

- Pharmacologic therapy for patients with diabetes and hypertension should be with a regimen that includes either an ACE inhibitor or an angiotensin receptor blocker (ARB). If one class is not tolerated, the other should be substituted
- Multiple drug therapy (two or more agents at maximal doses) is generally required to achieve blood pressure targets
- If ACE inhibitors, ARBs or diuretics are used, kidney function and serum potassium levels should be closely monitored



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**Briefly is also available  
online at [thehealthplan.com](http://thehealthplan.com)**

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## Seasonal flu reminder

This flu season, remember to use Q-codes when reporting the seasonal influenza vaccine. These codes replace influenza vaccine code 90658. Each Q code is attributed to the individual influenza vaccine products below to account for differences in manufacturing costs.

- Q2035 – Afluria
- Q2036 – Flulaval
- Q2037 – Fluvirin
- Q2038 – Fluzone
- Q2039 - Not otherwise specified

The Health Plan will no longer accept procedure code 90658 for the reporting of the seasonal influenza vaccine.

## Pediatric immunization reminder

Pediatric vaccination codes 90460 and 90461 replace codes 90465-90468 and are reported per vaccine/toxoid component. Providers should report code 90460 for each first vaccine/toxoid component administered and code 90461 for each additional component. The codes are to be billed on a single claim line with a count representing the number of vaccine/toxoid components being billed. Please note that reporting 90460 or 90461 multiple times for a single date of service will reject as a duplicate service. Do not report modifiers with vaccine administration codes. Routes of administration (e.g., intranasal, intramuscular, oral) have no bearing on the new administration codes. Routes of administration are identified by the vaccine code.

Please continue to use procedure codes 90471-90474 for immunization administration of any vaccine that is not accompanied by face-to-face physician or qualified health-care professional (e.g., physician assistant or nurse practitioner) counseling with the patient/family or for administration of vaccines to patients over 18 years of age.

# Medicare update

## Geisinger Gold updates for 2012

Medicare's annual election period is October 15 through December 7, 2011. This period is when beneficiaries can make changes in their plan selection. If you have any patients who are interested in Geisinger Gold, they can call (800) 631-1656, 8 a.m. to 8 p.m. seven days a week; TDD/TTY users call 711 or visit us online at [GeisingerGold.com](http://GeisingerGold.com).

We have made some changes to our plans for 2012. Classic 2 (HMO) has been discontinued, and most members will be automatically enrolled in Classic 3 (HMO). Members enrolled in a Classic or Preferred plan, and who live in Carbon, Lehigh or Northampton counties, will have to choose a new plan for 2012. If your patients have any questions regarding their coverage, they can call (800) 498-9731, 8 a.m. to 8 p.m. seven days a week; TDD/TTY users call 711 or visit us online at [GeisingerGold.com](http://GeisingerGold.com).

We will also send information to our provider offices outlining applicable Gold benefit information. This information can also be found online at [thehealthplan.com](http://thehealthplan.com), in the Health Care Provider section.



## Geisinger Gold Reserve MSA plans

Geisinger Gold Reserve Medical Savings Account (MSA) is a Medicare Advantage MSA plan authorized by the Centers for Medicare & Medicaid Services (CMS). An MSA plan differs from HMO, PPO or Medicare supplement plans by pairing a high deductible health plan with a checking account. Geisinger Gold Reserve MSA beneficiaries are free to see any provider willing to treat the enrollee and bill Geisinger Gold. Providers are not required to have a contract with Geisinger Gold in order to bill Geisinger for services rendered to an MSA member. Providers are reimbursed 100% of the Medicare fee schedule within 30 days of filing the claim. Enrollees should inform you, before obtaining services, that they have purchased Geisinger Gold Reserve MSA for their Medicare coverage. You do not have to be a contracted provider to see Geisinger Gold Reserve MSA enrollees.

Your agreement to bill Geisinger Gold is inherent in your decision to treat a Geisinger Gold Reserve MSA enrollee.

If you are a contracted provider, you must bill the correct Medicare payable fee-for-service codes in order for your claims to be processed. Procedurally, you bill Geisinger for Medicare covered services using MEDICARE PAYABLE codes, which may differ from the codes that you would normally bill for a Geisinger Gold HMO or PPO plan. Geisinger adjudicates your bill against Medicare allowed rates and

sends an Explanation of Benefits (EOB) to the MSA member and an Explanation of Payment (EOP) to you. You may then bill the MSA member.

If you provide services without verifying with your patient the plan that they have, you are deemed to accept 100% of the then-current Medicare fee schedule and must bill Geisinger for that member.

If you decide not to bill Geisinger Gold for an MSA enrollee, you should not provide services to the enrollee, except for emergencies.

If you have questions about Geisinger Gold Reserve MSA, please visit [thehealthplan.com/providers\\_us/index.cfm](http://thehealthplan.com/providers_us/index.cfm) or contact us at (800) 498-9731.

## Secured messaging for claims

The secured messaging feature enables you to communicate directly with our claims department through our website, [thehealthplan.com](http://thehealthplan.com). Simply log in, click "Your Secured Messages" button, type your claim related question or concern, and submit. Our claims department will review your question or concern and respond to you within 24-48 hours. This is an easy-to-use feature that ensures a quick response to your claim issue.



# Medical and pharmaceutical policy updates

The following is a summary of new, revised and recently reviewed medical and pharmaceutical policies. Please consult the full text of these policies online at [thehealthplan.com](http://thehealthplan.com). Printed copies are available by contacting your provider relations representative. Soon, information on policies and guidelines will be available exclusively online at [thehealthplan.com](http://thehealthplan.com). More details will be available in future issues of Briefly. New and revised policies are effective January 1, 2012.

\*Coverage requires prior authorization (PA)

## New Policies

### MP258 Hyperhidrosis

- Botulinum toxin A\* for the treatment of severe primary axillary or palmar hyperhidrosis continues to require prior authorization
- Endoscopic transthoracic sympathectomy and/or surgical excision of axillary sweat glands for the treatment of severe primary hyperhidrosis may be considered medically necessary when criteria are met
- The Health Plan does NOT provide coverage for the use of iontophoresis for the treatment of hyperhidrosis because it is considered experimental, investigational or unproven. (see MP214) The Geisinger Technology Assessment Committee evaluated this technology and concluded that there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this technology on health outcomes when compared to established tests or technologies.
- A list of additional Exclusions are included in the policy

### MBP93.0 Nulojix\*

- Requires prior authorization through Medical Management
- Eligible for coverage for prophylaxis against rejection in Epstein – Barr seropositive kidney transplants

### MBP92.0 Off-label Drug Use for Oncologic Indications\*

- Requires prior authorization through Medical Management

## Revised Policies

### MP19 Laser Treatment of Cutaneous Vascular Lesions

- Added exclusion - Pulsed dye laser for treatment of rosacea is considered experimental, investigational and unproven. and is NOT COVERED

### MP120 Intracavitary Balloon Brachytherapy for Breast Cancer

- Revised Indications to comply with recommendations of the American Society of Breast Surgeons

### MP79 Donor HLA Typing

- Removed Limitations and Exclusions sections from the policy

### MP104 - Continuous Subcutaneous Insulin Infusion Pump\*

- Continues to require advanced determination of coverage
- Revised criteria for coverage

### MP71 - Continuous Subcutaneous Glucose Monitor\* (CSGM)

- Continues to require advanced determination of coverage
- Revised criteria for coverage

### MP112 Wireless Capsule Endoscopy

- The Plan does NOT provide coverage for the use of the Agile patency capsule because it is considered experimental, investigational or unproven for evaluating patency of the gastrointestinal tract before wireless capsule endoscopy, and for all other indications. Although the device is FDA approved, there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this testing on health outcomes.

### MP69 Ultrafiltration

- Coverage limited to Medicare business segment to comply with CMS mandated coverage.

### MP47 Hyperbaric Oxygen Therapy

- Indications revised
- Additional exclusions added: chronic non-diabetic wounds; demyelinating disease; migraine or cluster-type headache

### MP58 Negative Pressure Wound Therapy\*

- Continues to require advanced determination of coverage
- Added contraindications

### MP56 - Management of Excessive Skin and Subcutaneous Tissue\*

- Continues to require prior authorization
- Revised exclusions

### MBP79.0 Provenge\*

- Continues to require prior authorization
- Revised criteria for coverage to include negative serology for Human Immunodeficiency Virus (HIV) 1&2, Human T-Cell Leukemia Virus (HTLV-1), and Hepatitis B and C

### MBP81.0 Prolia\*

- Continues to require prior authorization
- Added indications

### MBP5.0 Remicade\*

- Continues to require prior authorization
- Added indication for moderately to severely active ulcerative colitis in pediatric patients who have had an inadequate response to conventional therapy

### MBP57.0 Tysabri\*

- Continues to require prior authorization
- Revised Indication to include a recommendation by the American Academy of Neurology

Continued on page 5

## MP68 Reduction Mammoplasty

- Continues to require prior authorization
- Revised indications criteria

## Reviewed Policies

*The following policies were reviewed. No changes were made to the clinical content. References updated.*

MP 148 - Mobile Cardiac Outpatient Telemetry (MCOT)  
MP 202 - Interferential Stimulation  
MP 206 - Electrocardiographic Body Surface Mapping  
MP 207 - Corneal Hysteresis  
MP 221 - Suprachoroidal Delivery of Pharmacologic Agents  
MP 234 - Occipital Nerve Stimulation  
MP 200 - Osteochondral Autograft Transplant  
MP 24 - External Counterpulsation  
MP146 - Sympathetic Therapy  
MP147 - Artificial Intervertebral Disc  
MP118 - Quantitative Sensory Testing  
MP117 - Dry Hydrotherapy  
MP116 - Hippotherapy  
MP166 - MR Ultrasound Ablation of Uterine Fibroids

MP161 - Thermal Capsulorrhaphy  
MP181 - Suit Therapy  
MP214 - Iontophoresis  
MP20 - Transplant Services\*  
MP66 - ESWT\*  
MP50 - Pectus Deformity Surgery\*  
MP244 - Pelvic Floor Stimulation\*  
MP243 - Anorectal Fistula Repair Using an Acellular Plug  
MP217 - Polysomnography and Sleep Studies  
MP232 - Autism Spectrum Disorder Evaluation and Medical Management  
MP155 - Cooling Devices  
MP242 - Genetic Testing for Tamoxifen Metabolism  
MP159 - Voice Therapy  
MP187 - Cryoablation  
MP 105 - Phototherapy for SAD  
MP 83 - Therapeutic Hydrophilic Contact  
MP 219 - Percutaneous Neuromodulation Therapy  
MP 246 - Multigene Expression Assay for Predicting Recurrence in Colon Cancer  
MP 177 - Sensory Integration Therapy  
MP 15 - Experimental/Investigational  
MP 29 - Bone Growth Stimulator\*  
MP 201 - Obstructive Sleep Apnea

MBP17.0 - Alefacept (Ameive)  
MBP20.0 - Faslodex\*  
MBP61.0 - Flolan\*  
MBP78.0 - Istodax\*  
MBP39.0 - Naglazyme\*  
MBP41.0 - Natrecor\*  
MBP68.0 - Nplate\*  
MBP62.0 - Remodulin IV\*  
MBP51.0 - Vivitrol\*  
MBP 13.0 - Viscosupplementation\*  
MBP 31.0 - Erbitux\*  
MBP 80.0 - Xiaflex\*  
MBP 84.0 - Berinert\*  
MBP 85.0 - Cinryze\*  
MBP 86.0 - Kalbitor\*  
MBP 2.0 - Synagis\*  
MBP 74.0 - Cimzia\*  
MBP 46.0 - Dacogen\*  
MBP60.0 - Cerezyme\*  
MBP58.0 - Prialt\*  
MBP50.0 - Vectibix\*  
MBP71.0 - IV Ketamine

## Retired Policies

MP 02 - PET Scan  
MP195 - Functional MRI  
MBP70.0 - Mozobil

## Clinical Guideline Review

The Health Plan continues to solicit physician and non-physician provider input concerning clinical guidelines. The following clinical guidelines are currently being reviewed:

- Pediatric ADHD
- Colorectal cancer screening
- Fall prevention
- Osteoporosis
- Urinary incontinence

Your feedback is encouraged and appreciated. Comments should be sent to Phillip Krebs, at [pkrebs@thehealthplan.com](mailto:pkrebs@thehealthplan.com). Please provide your feedback by Dec 15, 2011.

The complete list of clinical guidelines is available online at [thehealthplan.com](http://thehealthplan.com). Providers are encouraged to contact their provider network management coordinator for assistance in accessing the guidelines online or to request hard copy. Comments can be sent to [pkrebs@thehealthplan.com](mailto:pkrebs@thehealthplan.com).

## Correct coding for ESRD

According to the National Kidney Foundation, chronic kidney disease (CKD) affects 20 million Americans, or one in every nine adults. With the increased incidence and prevalence of CKD, accurate documentation of the severity and type of disease and correct coding of end stage renal disease (ESRD) are more important than ever. Being familiar with codes makes the coding process easier and more efficient. Accurate coding ensures that your practice is compliant, streamlines the reimbursement process and reduces denials.

According to The International Classification of Diseases, 9th Revision, Clinical Modification 2012 (ICD-9- CM 2012), ESRD should be reported using code 585.6. ESRD is classified as the complete or near complete failure of the kidneys' ability to excrete wastes, concentrate urine, and regulate electrolytes to the extent that dialysis or kidney transplantation is needed to avoid multiple and severe complications or death from accumulation of fluids and waste products in the body.

**Stages of chronic kidney disease:** (GFR = glomerular filtration rate)

Stage I – GFR (>90) - Code 585.1

Stage II – (Mild) GFR (60-89) - Code 585.2

Stage III – (Moderate) GFR (30-59) - Code 585.3

Stage IV – (Severe) GFR (15-29) - Code 585.4

Stage V – GFR less than 15 - Code 585.5 - coded to 585.6 (ESRD) if dialysis required

The difference between Stage V and ESRD is that ESRD requires chronic kidney dialysis. **Please note: acute renal failure – Code 584, can also be assigned as an additional code. We encourage you to reference ICD-9-CM 2012 to ensure reporting of this code to the highest level of specificity.**

# HIPAA 5010

Effective January 1, 2012, changes resulting from the transition to Health Insurance Portability and Accountability Act of 1996 (HIPAA) Accredited Standards Committee (ASC) X12 version 5010 will impact electronic transactions exchanged between GHP and its trading partners.

All covered entities (e.g., health plans, health care clearinghouses, and health-care providers) will be required to begin using the new version 5010 transaction standard on Jan 1, 2012.

To ensure a smooth transition, GHP is currently testing 834 (Enrollment and Maintenance), 835 (Claim Payment/Advice), 270/271 (Eligibility/Benefit Inquiry and Response), and 837 (Claim) HIPAA 5010 transactions with the clearinghouses that function as intermediaries between GHP and the provider and with providers that send transactions directly. Over a dozen groups are already sending their production 834 transactions to us in the new HIPAA 5010 format.

Providers need to ensure that their clearinghouses or billing/service agents are ready to send claims in this new format to all insurers with whom they do business by January 1, 2012.

Along with changes to the claim transaction format, please note that as part of the 5010 requirements, PO boxes are no longer allowed to be sent as the billing provider's address on claims--a physical location must be sent. PO boxes, if used, may continue to be sent in the pay-to address location (address receiving payment) on the transaction. Please also note that the zip code submitted with the billing provider address must be the 9-digit zip.

To ensure a smooth transaction to this new data format, please work with your billing or service agent to assure this and other 5010 format requirements are met.

## Commercial formulary updates

As a general rule, drugs at tier 1 and tier 2 are considered preferred drugs, while non-preferred drugs are typically at tier 3. Prior authorization may be necessary for certain drugs. The table below represents recent updates to the Health Plan's formulary. For a hard copy of the entire formulary, please contact our pharmacy customer service team at (800) 988-4861, Monday through Friday, 8 a.m. to 5 p.m. or view it at [thehealthplan.com](http://thehealthplan.com). The 2012 commercial formulary will be available online at [thehealthplan.com](http://thehealthplan.com) in January 2012.

Drug	Status	Tier	Notes
Victrelis	NF	3*, t	Incivek preferred; 12 week initial authorization.
Incivek	F	3*, t	12 week authorization.
Xarelto**	F	3	Quantity limit of 34 tablets per dispense.
Lastacaft	F	3*, t	Alternatives include Azelastine and Pataday.
Fortesta	F	3*, t	Alternatives include Androderm patches and gel.
Simvastatin 80 mg	F	1*, t	Member must have been on Simvastatin 80 mg for at least 12 months prior or have failed both Lipitor and Crestor.
Optichamber	F	2	1 copay per unit; 2 units per year limit.

**\*For commercial only\*** Lipitor is expected to be available in generic form sometime after December 1, 2011. Please note that Geisinger will cover the brand Lipitor at Tier 1 and the generic will not be covered at this time.

### Status column key:

**Formulary (F)** -drug is a preferred product; prior authorization may still apply according to the table above

**Non-Formulary (NF)**-drug is not a preferred product; prior authorization will likely apply according to the table above

### Tier key:

\* =prior authorization applies for the traditional benefit

t = prior authorization applies for the triple choice benefit

\*\* = quantity limit applies

# Gold formulary updates

Drug	Status	Formulary A Tier	Formulary B Tier	Notes
Victrelis	F	2*	4*	Incivek preferred; authorization will be for 11 months
Incivek	F	2*	4*	12-week authorization
Xarelto**	F	2	3	Quantity limits apply
Lastacaft	NF			Formulary alternatives include Azelastine and Pataday
Fortesta	NF			Formulary alternatives include Androderm patches and gel
Eduvant	F	2	3	
Nulojix	F	2*	4*	
Potiga	F	2	3	
Banzel suspension	F	2	3	
Viramune XR	F	2	3	

**Status column key:**

**Formulary (F)** -drug is a preferred product; prior authorization may still apply according to the table above

**Non-Formulary (NF)** -drug is not a preferred product; prior authorization will likely apply according to the table above

**Tier key:**

**Formulary A-** Geisinger Gold standard formulary

**Formulary B-** Geisinger Gold \$0 deductible formulary

\* =prior authorization applies

\*\* = quantity limit applies

To request a prior authorization, please contact the GHP Pharmacy Department at (800) 988-4861, Monday- Friday, 8 a.m.- 5 p.m.

**The 2012 Gold Formulary is available online at [thehealthplan.com](http://thehealthplan.com) or by calling (800) 988-4861**

## GHP policies and procedures available online

The GHP Participating Provider Guide is available online at [thehealthplan.com](http://thehealthplan.com). You may also request a copy of the full guide, or select sections, by calling your provider relations representative.

The Participating Provider Guide includes important Health Plan policy and procedure information, including:

- Member rights and responsibilities (HMO, PPO and Gold)
- Medical management information (communicating denials of coverage, how we make medical management decisions and more)
- Quality Improvement information
- Privacy information
- Minimum standards for medical record documentation

## Pharmaceutical management

For information regarding pharmaceutical management procedures including generic substitution, prior authorization, therapeutic interchange, step therapy and other requirements that may apply, please refer to:

- [thehealthplan.com/providers\\_us/medical.cfm](http://thehealthplan.com/providers_us/medical.cfm), under Formulary Information

For a hard copy of the entire Formulary, please contact our pharmacy customer service team at (800) 988-4861, Monday through Friday, 8 a.m. to p.m. or view it at [thehealthplan.com](http://thehealthplan.com).



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HPM50 ad Dec 2011 11/11/11

## Important pharmacy processing changes for 2012

For members with prescription benefits, GHP is making improvements to member claims processing methods at the pharmacy. Beginning January 1, 2012, MedImpact will process member prescription drug claims at the pharmacy. Our top priority is to make sure this transition occurs with no service interruption for our members, providers and pharmacies. Please note the following:

- New prescription benefit cards will be distributed (to applicable members) before this transition takes effect on January 1, 2012. Beginning January 1, members will need to present their new prescription benefit card to their pharmacy, including mail order pharmacy, for prescriptions to be paid
- Member ID numbers will remain the same
- Members may encounter a slight delay in prescription processing during their first 2012 prescription fill
- Argus prescription benefit cards will not be accepted after December 31, 2011

Additional information will be available in the coming months. If you have questions, please call (800) 988-4861 or (570) 271-5673; TDD/TTY 711.