Part D Drug List Shopping Form (Not for Part B or OTC)

Client Name:

LIST YOUR PREFERRED PHARMACY FULL NAME + ZIP CODES:

☐ No RX ☐ I have no pharmacy preference ☐ I must have certain brand name drugs as indicated

☐ Will go to what ever pharmacy is best ☐ I prefer to use mail order ☐ Use generics where available

☐ I have drugs covered as an exception after we appealed (Note)

IMPORTANT NOTES:

In the last column indicate TABLET, CAPSULE, TUBE, VIAL, PEN, CANISTER, PATCH, BOTTLE, SOLUTION, CREAM, GEL, LOTION, BOX, etc. Note exact dosage: gm, mg, etc. Take info off your prescription including all verbiage (er, X1).
Please note how you normally refill each med, such as **"1 inhaler every 3 months, or 90/3 mo."**
Your choices are: every month, once every 2 months, every 3 months, every 6 months or once every 12 months.

Type or Print Clearly **Please note: "AS NEEDED" IS NOT AN OPTION** **Note any RX you already have an exception for**

Print exact precise name of drug	# taken per	Day/Week/Mo	Dosage/mg-etc.	How filled? (30/month)	Check one:	Other Comments
Metformin (Example)	2	Day	1000 mg	180 / 3 Mo	❑ Brand Name ☑ Generic	Generic Tablets
Print exact precise name of drug	# taken per	Day/Week/Mo	Dosage/mg-etc.	How filled? (30/month)	Check one:	Other Comments
Insulin Lispro Pen 100 Units/ML (Example)	3 Injections	Day	17 Units	5 Pack / 3ML Pen / Mo	❑ Brand Name ☑ Generic	For Humalog Pen
Print exact precise name of drug	# taken per	Day/Week/Mo	Dosage/mg-etc.	How filled? (30/month)	Check one:	Other Comments
					❑ Brand Name ❑ Generic	
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					❑ Brand Name ❑ Generic	
Print exact precise name of drug	# taken per	Day/Week/Mo	Dosage/mg-etc.	How filled? (30/month)	Check one:	Other Comments
					❑ Brand Name ❑ Generic	

You can also log into your **mymedicare.gov** account and update your drug list there. Print out or take screen shot of the web page and send it to us.

Type or Print Clearly **Please note: "AS NEEDED" IS NOT AN OPTION** **Note any RX you already have an exception for**

Print exact precise name of drug	# taken per	Day/Week/Mo	Dosage/mg-etc.	How filled? (30/month)	Check one:	Other Comments
					❑ **Brand Name** ❑ **Generic**	
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					❑ **Brand Name** ❑ **Generic**	
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