# Your prescription drug list

Everence®

Completing this form provides information to help us research which Medicare Part D prescription drug plan may best meet your needs. Please fill out one form per person.

1. Date _____
2. Name _____ 3. Birth date _____
4. Address _____
   Street City State ZIP code
5. County _____
6. Phone number _____ 7. Email address _____
8. Medicare number _____
   a. Part A effective date_____ b. Part B effective date _____
9. Preferred pharmacy _____ Alternate pharmacy_____
   Do you prefer using a: ☐ Local pharmacy for 30 day refills
   ☐ Local pharmacy for 90 day refills
   ☐ Mail order service for 90 day refills
10. Prescriptions
    - List your prescription drugs, **not including over-the-counter drugs, vitamins, herbal remedies or supplies.**
    - Be as accurate as possible. Write down the names and doses as they are stated on your receipts or prescription bottles.

**Oral medication**

| Drug name | Tab/capsule and strength | # per day |
|---|---|---|
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| | | |
| | | |
| | | |

**Inhalers/sprays**

| Drug name | Size of inhaler/spray | Number filled annually |
|---|---|---|
| | | |
| | | |
| | | |

**Creams/drops**

| Drug name | Size of tube or bottle | Number filled annually |
|---|---|---|
| | | |
| | | |
| | | |

**Other**

| Drug name | Dosage | Frequency |
|---|---|---|
| | | |
| | | |

This information is used **only** to help you decide on a Part D prescription drug plan. The law imposes fines and/or imprisonment for using this information for improper or illegal purposes. Therefore, we will not share it with anyone for any other reason.