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 County

5. Phone number _____ 6. Email address _____

7. Medicare number _____

   a. Part A effective date _____ b. Part B effective date _____

8. 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

   Would you be willing to change to another local phamacy to save on drug costs? ☐ Yes ☐ No

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

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.