PLEASE DO NOT SEND MORE THAN ONE COPY
(EMAIL, FAX OR SNAIL MAIL)
SEPARATE SHEETS PER PERSON

AGENT:

**PLEASE FILL OUT ALL FIELDS TO AVOID DELAY **

* Please do not list vitamins or over-the-counter medications
* If you take pills only "as needed" please put the average quantity you use per month
* If you use insulin, indicate how many pens or vials per month
* If you use a cream or gel, indicate how many tubes or bottles (and WHAT SIZE) per MONTH
* If you use inhalers, indicate size and how long one lasts

Name:________________________ **Phone:**________________ **Date:**__________

Address:________________ **City:**____________ **County:**__________ **Zip:**______ **Home Zip**______

Email:________________________ **CURRENT DRUG PLAN:** ________________________

Pharmacy: ______________ **Pharmacy #2:** (Only if you're willing to change) ______________ **Mail Order: Yes___ No___**

Medication Name (DO NOT LIST ANY OVER THE COUNTER DRUGS)	Capsule or Tablet	Dosage	Daily Quantity	Tubes/Bottles Pens/Vials (Per Mo)	Is Generic OK? Yes or No

NOTE: If you get an Rx from GoodRx or Canada or any other method besides your drug plan, please indicate the cost so we can run list with and without that Rx.

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