Prescription Drug Plan Search

Please use an additional sheet of paper if necessary.

Client Name: _____ **Current Drug Coverage:** _____

Client Zip Code: _____ **Client County:** _____

Preferred Pharmacy(s) First: _____ Second: _____

Does your client prefer mail-order prescriptions? ☐ Yes ☐ No

How often does the client prefer to fill their prescription(s)? ☐ 30 days ☐ 90 days ☐ Other _____

Drug Name	Can the generic be taken? (if applicable)	Drug Format Type (tab, cap, cream, patch, vial, pen, etc)	Dosage	Quantity	Frequency Drug Needs Taken
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				

FOR AGENT USE ONLY

Drug List Source: _____ **Drug List ID/Quote #:** _____ **Drug Quote Date:** _____

(Medicare.gov or other drug-pricing tool) *(Medicare.gov uses as password)*