WOOTEN
AGENCY

Drug Plan Information Request for 2022

Please follow these instructions to submit this PDF to us.

1. Fill out both pages of this form with your computer's PDF viewer.
2. Save it to your computer. No need to print or scan!
3. Email it to **cedwooten@gmail.com.**

Name: _____ **Phone:** _____

Address: _____

ZIP Code: _____ **County:** _____

Would you like your results by email? ◯ Yes ◯ No

Email: _____

Current Drug Plan (from your ID Card): _____

What is your preferred pharmacy? _____

Do you receive your prescriptions by mail? ◯ Yes ◯ No

Would you be willing to change pharmacies to lower your cost? ◯ Yes ◯ No

If you receive a Low-Income Subsidy (Extra Help) for your Part D plan, please select:

◯ Full Extra Help ◯ Partial Extra Help

Additional Comments: _____

_____

_____

_____

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Instructions: Please write the entire name as printed on the prescription bottle. If the drug is generic please print the entire generic name. You do not need to include any over the counter drug names. **For insulin, please list how many pens/vials used per month.**

	Drug Name *(Generic or brand name; as printed on bottle.)*	Dosage Amount and Type *(Capsule–Tablet)*	Pill Amount Per Day	Refill Amount *(30–60–90 Day)*
E.g.	*Levothyroxine*	*0.05 Mg – tablet*	*1*	*30*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

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