

REMEMBER:

- 1. No over-the-counter medications, vitamins or supplements.**
- 2. No pharmacy medication lists.**
- 3. Indicate number of weeks between refills for medications that come in the form of drops.**

Preferred Pharmacy: _____

Generic Name or Brand Name of Drug	Dosage (ex. mg, ml, GM)	How Many Pills a Day	How Often Filled (30 or 90 days)
EX: 1) lisinopril/hctz 2)timolol maleate ophthalmic SOL 0.5%	20/25MG 5mL Bottle	1/day 1 drop/day	90 days 1 bottle per month

I have requested the Ozaukee County Elder Benefit Specialist’s assistance in searching for a Medicare Part D or Medicare Advantage Plan. I understand the accuracy of the search depends on the information I have provided.

Signature: _____

Date: _____