Leslie A. Williams
INSURANCE SERVICES

2021 Plan Year Part D
Evaluation Form

Please return by 10/30/2020 via

Fax: 530-222-8231, Email: jennifer@lawilliamsinsurance.com, Web: www.lawilliamsinsurance.com
Mail: 2295 Hilltop Dr, Suite 5, Redding, CA 96002
Note: Even if you do not take prescriptions, we will need that notated below and the form returned to our office for your file.

Date: _____ Name: _____

Which retail pharmacy do you use if you pick up an RX locally? _____

Do you receive prescriptions at **no cost** from your doctor's office? _____ If so, please list the RX names here. _____

Do you receive **assistance** for any prescriptions through a patient assistance program? If so, please list the RXs and programs you use so that we may better assist you. _____

Please complete the sections below listing all of your current prescriptions. *NOTE: There are different sections for each form of prescription-* **Oral, Topical, Self-Injectable and Inhaled. (See both sides of the form. You may attach an additional sheet if needed to list your prescriptions.)**

Oral Prescriptions: tablets, capsules, liquids, etc. (Examples shown in gray below.)

Full Prescription Drug Name *Ex. Glipizide/metformin HCL Ex: Bupropion HCL SR Ex. Lorazepam CON 2mg/ml*	**Type:** *Tablet, Capsule, Liquid?*	**Dosage Size** *(ex: 60 x 2.5-250m, 30 x 150 mg, 1 x 30 ml, 2 x 4 ml ?)*	**Frequency filled?** *(1 a month, 2 a year, or?)*	**Quantity?** *(How many do you get a refill? ex. 120 pills every month)*	**Mail or Retail?**

Topical: Any cream, ointment, gel, foam or medication applied externally. (Examples shown in gray below.)

Full Prescription Drug Name *Ex: Premarin Cream .625MG* *Ex: Clobetasol Propionate E Foam .05%* *Ex: Ultravate LOT .05%* *Ex: Androgel Gel 1.62% 20.25mg/1.25gm*	**Type** *Cream, foam, ointment, gel?*	**Container** *Tube, can, bottle, box, packet, pump?*	**Size of tube/can/ bottle/pump?** *(ex. 20 ml, 1 gm)* **Box size?** *(ex 30 boxes, 1 packet)*	**Frequency filled?** *(once a month, twice a year, or?)*	**Quantity?** *(How many do you get a refill? 2 tubes? 1 bottle?)*	**Mail or Retail?**

Self-Injectables: Anything prescription drug you self-inject, including insulin. (Examples shown in gray below.)

Full Prescription Drug Name *Example: Insulin Lispro INJ 100/ML* *Example: Vit B-12 INJ 1000MCG*	**Type:** *Pen, vial or?*	**Size of vial?** *(ex.10 ml, 25 units,10/1ml)* **How many pens in a pack?** *(ex. 5 pens 3 ML)*	**Frequency filled?** *(1 a month, 2 a year?)*	**Quantity?** *(How many vials/pens do you get a refill?)*	**Mail or Retail?**

Inhaled Medications: By mouth or nose (examples shown in gray below)

Full Prescription Drug Name *Ex: Advair HFA AER 115/21* *Ex: Advair Diskus AER 100/50* *Ex: Albuterol Sulfate Neb .083%*	**Type:** *(Inhaler, blister pack, spray, bottle, container, vial?)*	**Size** **Inhaler/bottle/contained size?** *(ex: 8 gm)* **Blister pack size?** *(example 14)*	**Frequency filled and how much?** *(1 inhaler a month, 1 inhaler twice a year?)*	**Retail or Mail?**

Signature_____