Current Medication List

Your Name:____ **Date**:__________________________

<u>Complete</u> Drug Name from Bottle/Container	Dosage / Container Size See list below	Form See list below	Quantity Per Refill	Refill Frequency See list below	Generic OK (Y)es or (N)o	Using GoodRx* (Y)es or (N)o
EXAMPLES						
Metoprolol Succinate ER	50mg	Tab	90	Q	Y	N
Albuterol Sulfate HFA	90mcg/8.5g	Inhaler	1	M	Y	Y

FORM: Tab Cap Inhaler Drops Patch Injection Vial Lotion Cream Ointment Gel

DOSAGE/SIZE: Be sure to list <u>BOTH</u> dosage and container size for Inhalers, Drops, Lotions, Creams, Ointments and Gels

REFILL FREQUENCY: (M)onthly (Q)uarterly (SA)Semi-Annually (A)nnually (BM)Every 2 months

DO <u>NOT</u> list "AS NEEDED" – Complete Refill Frequency with one of the above options

*Answer (Y)es if using GoodRx or any other discount drug plan to fill medication

Return form to Jenell Sobas, Key2Medicare Insurance

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Email: jenell.sobas@key2medicare.com

Phone: 303-484-1763

Disclaimer: Sharing this information with us is strictly voluntary. The information is used to create a more accurate analysis of your specific needs.