Name:_____

Medicare Part D – Prescription Drug List

LEGACY
PLANNING SERVICES, LLC

In order for us to do the best job possible for you, please provide us with the following:

1. The **Exact RX Name**, all words, with any initials after it.
2. **Exact SPELLING** is important: If you take the generic, give us **THAT** name.
3. Need **EXACT DOSAGE**, mg's, mcg's, solution, cream, or injection.
4. How often taken…**(FREQUENCY)** 1/day, 2/day, 3 x's/week, etc…occasionally.
5. Please provide the name & phone # of your **PREFERRED** pharmacy.
6. Return to us via FAX: 215-933-6185 or E-MAIL: Info@Legacy-Services.com.
   (Give us a call if you have any questions: 215-968-9600)

* Pharmacy Name:_____

Pharmacy Phone #_____

* Date of Birth:_____

* Zip Code:_____

	Medication Name – YOU TAKE	Dosage	Frequency	Generic	Brand	Comments/Notes
Ex:	*Metropolol Succinate ER*	*10 mg*	*1 per day*	Please specify		
Ex:	*Lipitor*	*20 mg*	*1 per day*	by checking in the		
Ex:	*Prednisone*	*10 mg*	*Occasionally*	corresponding box		
1.				☐	☐	
2.				☐	☐	
3.				☐	☐	
4.				☐	☐	
5.				☐	☐	
6.				☐	☐	
7.				☐	☐	
8.				☐	☐	
9.				☐	☐	
10.				☐	☐	
11.				☐	☐	
12.				☐	☐	
13.				☐	☐	
14.				☐	☐	

PLEASE RETURN TO: Legacy Planning Services, LLC: FAX: 215-933-6185 or E-MAIL: Info@Legacy-Services.com