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| **Name:** | | | **Zip Code:** |
| **Phone:**  **Work Home Cell** | | | |
| **County:** | **Pharmacy First Choice:** | **Pharmacy Second Choice:** | **Mail Order: Yes No** |
| **Which Plan Year? 2017 or 2018** | | **Current Part D Plan (if currently enrolled):** | |
| ***Please only list Prescribed Medications. Do not include Vitamins, Supplements or OTC drugs.*** | | | |
| **Name of Medication** | **Dosage** | **How many times a day?** | **Willing to switch to generic** |
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