Medication Information[2,3]

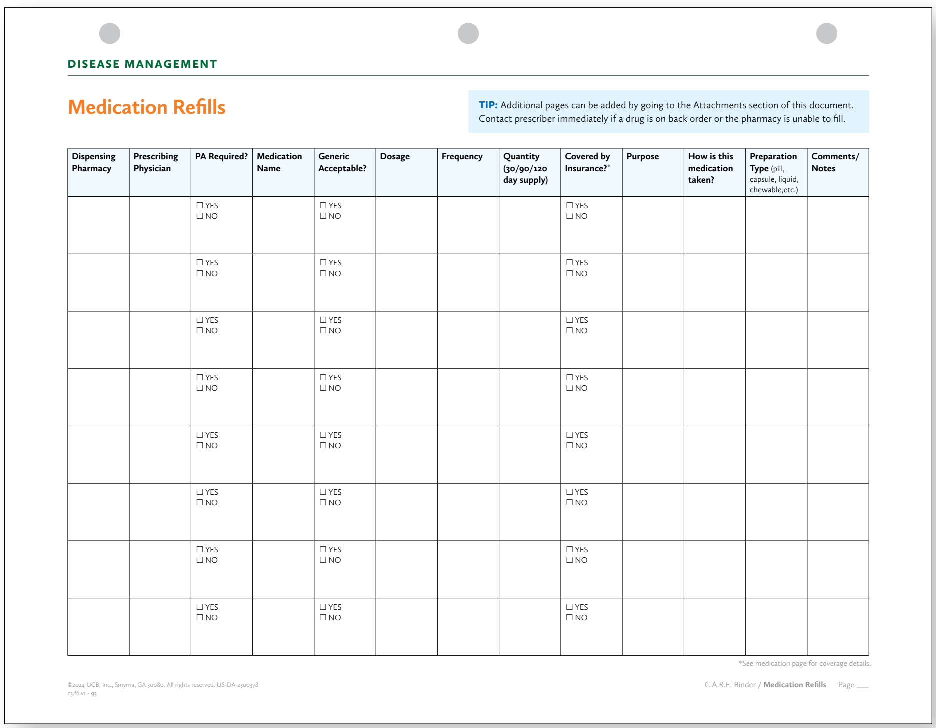
Use the summary page to document your loved one's medications.

Below are some helpful tips to keep in mind as you manage your loved one's medications.

- Does this medication require a prior authorization (PA)?
- Make a note of the following important information for your prescription, such as pharmacy name/contact info.
- Have a point of contact at your provider's office in case anything goes awry with filling your prescription.
- Determine what the estimated turnaround time is for prescription requests – especially if it's different for submissions via a secure web portal vs. requests by phone.
- Contact prescriber immediately if a drug is on back order or the pharmacy is unable to fill.

TIP: Request as soon as you can to refill a prescription (retail or specialty) – if it's too soon to refill, ask the pharmacist when is the soonest you can make a request. It's especially important to manage your loved one's anti-seizure medications (ASMs) to ensure they don't run out. If possible, it may help to ask for the medication to be put on an automatic refill. Also, pay attention to weekends and holidays and try to avoid needing a refill around those times, when possible.

The Medication Refills Chart (sample shown at right) has been included in the C.A.R.E. Binder for your convenience. Use the summary page to document your loved one's medications.



DISEASE MANAGEMENT

Medication Refills

TIP: Additional pages can be added by going to the Attachments section of this document. Contact prescriber immediately if a drug is on back order or the pharmacy is unable to fill.

Dispensing Pharmacy	Prescribing Physician	PA Required?	Medication Name	Generic Acceptable?	Dosage	Frequency	Quantity (30/90/120 day supply)	Covered by Insurance?*	Purpose	How is this medication taken?	Preparation Type (pill, capsule, liquid, chewable,etc.)	Comments/ Notes
		☐ YES ☐ NO		☐ YES ☐ NO				☐ YES ☐ NO				
		☐ YES ☐ NO		☐ YES ☐ NO				☐ YES ☐ NO				
		☐ YES ☐ NO		☐ YES ☐ NO				☐ YES ☐ NO				
		☐ YES ☐ NO		☐ YES ☐ NO				☐ YES ☐ NO				
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		☐ YES ☐ NO		☐ YES ☐ NO				☐ YES ☐ NO				
		☐ YES ☐ NO		☐ YES ☐ NO				☐ YES ☐ NO				
		☐ YES ☐ NO		☐ YES ☐ NO				☐ YES ☐ NO				

*See medication page for coverage details.

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C.A.R.E. Binder / **Medication Refills** Page ___

Detailed Information on Medication

TIP: Additional pages can be added by going to the Attachments section of this document.

Medication Name:

Purpose:

Generic Acceptable? ☐ YES ☐ NO

Does this medication require a prior authorization (PA)? ☐ YES ☐ NO

PA renewal date:

TIP: Set a reminder on your phone to go off at least two weeks before the prescription expires to remind you to start the PA process.

RX Number:

Dosage:

Frequency:

Quantity:

Prescribing Physician Name:

Phone:

Fax:

Email:

Dispensing Pharmacy: ☐ Local Pharmacy ☐ Specialty Pharmacy

Contact Name:

Address:

City:

State:

Zip:

Phone:

Fax:

Email:

Please indicate if identification is required when picking up this medication from the pharmacy. ☐ YES ☐ NO

TIP: You may have different medications that are dispensed by different pharmacies. Indicate the list of medications each pharmacy provides.

Covered by insurance ☐ YES ☐ NO

Co-pay cost:

Prescription or Co-Pay Assistance Program Available? ☐ YES ☐ NO

Name/Info for Assistance Program(s):

Phone:

Fax:

How is this medication taken?

Preparation Type (pill, capsule, liquid, chewable, etc.)?

Additional Comments/Notes: