Instructions for Filling Out the Medicare Drug Plan Pre-Enrollment Information Form

FRONT SIDE OF THE FORM:

1. Enter your name just as it appears on your Medicare card.
2. Please list your phone number in case we have to reach out to you.
3. Tell us your date of birth.
4. Give us your mailing address and zip code so we can get the results back to you (if Social Security and or Medicare have a different address also provide the ZIP CODE only for the address where Social Security and/or Medicare send you notices).
5. Write your Medicare number just as it appears on your card.
6. Give us the dates that Medicare Part A and Part B became effective; this information can be found on the front of your Medicare card.
7. Do you have an account set up for the Medicare.GOV web site? If yes, please list your User Name and your Password. (SHINE may have set up that account and we would have mailed you information about the User Name we created as well the password; or, some of you may have set up your own account on the Medicare web site). **In either case, we need the User Name and the Password.**
8. If you do not have an account we will create one for you. Do you give us permission to do so? We will send you the account information for safe keeping. Please sign the form giving us permission so we can do a Part D search for you.

****Please be advised that no Part D drug searches will be performed unless an account has been previously created on the Medicare web site. If you do not have an account, do you allow us to create one for you?** If NO, we will return your information to you without doing a search. You can then call Medicare for further assistance: 1-800-633-4227.**

WHY DO WE NEED YOUR PERSONAL INFORMATION?

Drug information is stored on the Medicare web site **only if a Medicare account has been created** – either by you or by us. Having a Medicare account is the only way we can know the name of your current plan, what prescriptions you are taking (prior claims will be brought into the search) **and** if you are getting assistance through a program such as Extra Help.

WHAT DO WE DO WITH YOUR PERSONAL INFORMATION WHEN THE SEARCH IS COMPLETED?

All forms are shredded. We do not pass along any of your personal information to anyone. We do not keep any of your personal information. If you want the form back, just ask; we'll be happy to return it to you.

BACK SIDE OF THE FORM:

1. Tell us which pharmacy you use. Let us know if you would switch to a different pharmacy if your costs would be lower for next year.
2. List the med name just as it appears on the bottle. Do not list Lipitor if you are taking the generic Atorvastatin Calcium. The computer system defaults to generics for all meds during the drug search – assuming the generic is available. **If you must take the brand name because the generic is not effective TELL US. Do not make us guess!** If we have to, we will call you if we are unsure about the information you entered – however this will cause delays. **Help us out.**

CRITERIA FOR FILLING OUT YOUR LIST OF MEDICATIONS

We need to know the strength and dosage for each medication that you take. Tablets and capsules are easy to list. But insulin pens, creams, lotions, powders, patches, and inhalers can be confusing.

We need to know how much of each medication that you **BUY** each time you order your medications. Do you buy once a month, every three months or once a year? **TELL US.**

We do not want to know how many inhaler puffs or eye drops or lotion, etc. that you use or when you use them. We don't know what you mean when you write "As Needed". You MUST tell us how often you **actually purchase** an "As Needed" Medication. We are not allowed to guess!

If we need clarification on the information that you send to us, we will call you. If we are unable to reach you quickly, your drug search will be delayed, or possibly returned without the Medicine being included if we do not hear from you within 1 week. Thank you in advance for doing your best with your drug list. The list below provides guidance on how to write the dosage of some problem medications.

(1) **CREAMS**: Creams come in bottles with different sizes. An example is Hydrocortisone. Do you buy a bottle once a month or once every three months?

(2) **OILS:** Oils come in vials with different sizes. An example is Estradiol. What size is the vial? Do you buy a vial once a month or once every three months?

(3) **EYE DROPS:** Eye drops are lotions or emulsions that come in bottles or vials with different sizes. An example is Lumigan. What size bottle or vial? How many do you buy per month?

(4) **PATCHES**: Patches come in boxes with different amounts. An example is Lidocaine, which comes in a box of 30 patches. How many patches do you use per month?

(5) **OINTMENTS:** Ointments come in tubes with different sizes. An example is Mometasone Furoate. What size tube? How many tubes do you use per month or in a year?

(6) **INHALERS:** Inhalers come in packages with different sizes. Some are emergency inhalers; others provide long lasting relief. Emergency inhalers include ProAir, Proventil, Ventolin or albuterol sulfate. How many do you buy per month or a year? Advair Diskus provides longer lasting relief; it comes in a package of 60 powders per month. How many packages do you buy per month?

(7) **POWDERS:** Powders come in packages or bottles with different sizes. An example is Nystatin. What size is the bottle? How many bottles do you buy/use per month?

(8) **INSULIN:** Insulin comes in vials or cartridges. An example is Humalog. Tell us the size of the vial. How many vials do you buy/use per month?

(9) **INSULIN:** Insulin can also come in pens. An example is Lantus. Tell us how many pens you use per month.

(10) **AS NEEDED:** Some prescriptions have PRN, or "As Needed" written on them. An example is Nitroglycerine Sublingual. How often do you buy? Once every three, six or twelve months?

DO NOT RETURN THIS SHEET with Your Medicare Drug Plan 2022 Pre-Enrollment Information Form

SHINE PROGRAM – WEYMOUTH ELDER SERVICES 781-682-6140

Medicare Drug Plan 2022 – Pre-Enrollment Information

Print Name: _____ **Phone:** _____ **Date of Birth:** _____

Street: _____ **Apt #:** _____ **City:** _____ **State:** _____ **ZIP:** _____

Medicare Number: _____ **Effective Date of Medicare A:** _____ **B:** _____
As it appears on your Medicare Card – Month and Year

Medicare Account: (If you have one) **Username:** _____ **Password:** _____

SHINE WILL ASSIGN A USERNAME, PASSWORD, and PASSWORD HINT question if you do not have a Medicare Account.

Do you give SHINE permission to create a Medicare Account for you? ☐ YES ☐ NO

By signing you authorize SHINE to use/create your Medicare Account:

(Please sign) _____ **Date:** _____

If you do not provide Medicare Account Info or allow SHINE to create a My Medicare Account, your information will be returned with No Search Conducted

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Do you have a Medicare Part D Drug plan? ☐ YES ☐ NO **Name of plan:** _____

SHINE will not conduct a Part D search if you are enrolled in any of the following plans:
(1) Medicare Advantage (i.e. a Medicare PPO, Medicare HMO); (2) Federal Blue Cross/Blue Shield; (3) you are on Medicare and covered by a retiree plan sponsored by your private employer (including Medicare Part D Plans Administered by AON or VIA; (4) a GIC Medicare plan; or, (5) a retiree plan offering Medicare coverage by your city/town. CONTACT YOUR PLAN DIRECTLY FOR 2022 COVERAGE INFORMATION.

EXCEPTION: SHINE counselors will do a search if you want to leave a Medicare Advantage plan to enroll in a Part D plan and a Medigap plan. Or, the retiree plan sponsored by your private employer is ending and you want to do a Part D plan with a Medigap plan.

Are you enrolled in Prescription Advantage? ☐ YES ☐ NO ☐ No, but I have applied

Do you receive help with Medicare prescription drug plan costs (LIS/Extra Help)? ☐ YES ☐ NO

Are you enrolled in MassHealth? ☐ YES ☐ NO

NOTE: There are benefit programs that might help with your health care costs. Do you want us to check your eligibility?

☐ YES ☐ NO, not at this time ☐ MARRIED ☐ WIDOWED ☐ SINGLE

If yes, tell us your GROSS monthly income for you and your spouse combined: $_____

Requests for Part D searches must be received by Weymouth SHINE Counselors no later than Friday November 11, 2022. All requests received after that WILL BE RETURNED.

OVER → **PLEASE LIST YOUR PRESCRIPTION MEDICATIONS ONLY ON THE BACK SIDE OF THIS FORM:**

What pharmacy do you use?_____

Pharmacy choice can impact your costs. Would you change your pharmacy to save money? Yes__ No__

If yes, name specific pharmacies you would use: _____

I only want to use mail order with my drug plan: Yes_____ No_____

IMPORTANT: If you use **inhalers, creams, shampoos or lotions –** how often do you buy them? Once a month, every three months? What size tube, jar or bottle? **Insulin** – how many pens or vials do you use per month? If a medication including inhalers is "as needed" how many do you buy in a year (1, 2 Other)? **Please be specific.**

Drug Name Example: Metoprolol Succinate Novolog FlexPen * **AS IT APPEARS ON THE BOTTLE:** IF YOU TAKE GENERIC LIST THE GENERIC NAME * **DO NOT LIST** VITAMINS, ASPIRIN, OR OTHER OVER THE COUNTER NON-PRESCRIPTION ITEMS	**Drug Strength & Dosage** Example: 50 Mg. – one per day 8 Pens per month * **WRITE TABLET or CAPSULE, VIALS, TUBES, BOTTLES (with the size of bottle)** * **LIST MONTHLY QUANTITIES** * **DO NOT WRITE "AS NEEDED" AS A QUANTITY – ESTIMATE HOW MANY AND HOW OFTEN?**
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