STRATEGIC HEALTH INSURANCE
Powered by the David M. Gilston Agency

2025 Current Prescriptions

Name _____

Zip Code _____ County _____

Phone _____ Email _____

Current RX Plan _____ Current Premium $ _____

Preferred Pharmacy _____

Please use <u>this chart</u> to fill out your Medication Information:

Please DO NOT put vitamins or over the counter drugs on this list. Thank you!

Full Name of Medication	Dosage	Quantity Per Month	Generic (G) OR Brand (B) **Write Initial**	Form (Ex. Tablet, Capsule, Gel, Cream, etc.)	Refill Frequency		
					30 Days	90 Days	Other

If you have a <u>Medicare Advantage Plan</u>, or want to change to one, please complete below:

Primary Physician Name & Phone #: _____

Specialist Name & Phone #: _____

Specialist Name & Phone #: _____