

## Part D plan checklist

- Does this plan cover my drugs? Are my drugs covered specifically for my condition?
- If it doesn't cover a drug I take, does it cover one that will work for me? (Ask your doctor.)
- How much will I pay at the pharmacy for the drugs I need?
- What costs should I expect to pay for my drug coverage (premiums, deductibles, copayments)?
- Are my pharmacies preferred and in-network?
- Will enrolling in this plan affect my existing drug/health coverage?
- Does this plan place any coverage restrictions on my covered drugs?

Plan name: \_\_\_\_\_

Plan phone number: \_\_\_\_\_

Formulary		
Are my prescription drugs on my plan's formulary (list of covered drugs)?		
<b>Name of drug</b>		
_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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Costs
Does my plan have a deductible? Yes <input type="checkbox"/> \$ _____ No <input type="checkbox"/>
How much is the premium? \$ _____
What are the estimated copays/ coinsurance costs for
Brand-name drugs? \$ _____
Generic drugs? \$ _____

Pharmacies
Is my pharmacy in my plan's network? Yes <input type="checkbox"/> No <input type="checkbox"/>
Can I use a mail-order pharmacy? Yes <input type="checkbox"/> No <input type="checkbox"/>
Can I fill my prescriptions if I travel away from the plan's service area? Yes <input type="checkbox"/> No <input type="checkbox"/>

Coverage Restrictions		
<b>Prior authorization</b>		
Do I have to get prior approval before my drugs are covered?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, which drugs? _____		
<b>Quantity limits</b>		
Does this plan limit the amount of drugs I can get?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, which drugs? _____		
<b>Step therapy</b>		
Do I have to try a cheaper drug before my plan will cover a more expensive one?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, which drugs? _____		