Pharmacy Name
Address
City, St Zip

<Date Prepared>

PATIENT NAME
ADDRESS
CITY, ST ZIP

Dear <Patient Name>:

Thank you for talking with me on <CMR Date> about your health and medications. Medicare's MTM (Medication Therapy Management) program helps you make sure that your medications are working.

Along with this letter are an action plan (Medication Action Plan) and a medication list (Personal Medication List). **The action plan has steps you should take to help you get the best results from your medications. The medication list will help you keep track of your medications and how to use them the right way.**

- Have your action plan and medication list with you when you talk with your doctors, pharmacists, and other healthcare providers.
- Ask your doctors, pharmacists, and other healthcare providers to update them at every visit.
- Take your medication list with you if you go to the hospital or emergency room.
- Give a copy of the action plan and medication list to your family or caregivers.

If you want to talk about this letter or any of the papers with it, please call <Pharmacist Name> at XXX-XXX-XXXX between the hours of <Pharmacist hours of availability>. I look forward to working with you and your doctors to help you stay healthy through the CareSource Advantage® (HMO SNP) MTM program.

Sincerely,
<Pharmacist Name>
Pharmacist

H6178_OHMSNP720

Pharmacy Name
Address
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MEDICATION ACTION PLAN FOR PATIENT NAME, DOB:XX/XX/XXXX

This action plan will help you get the best results from your medications if you:

1. Read "What we talked about."
2. Take the steps listed in the "What I need to do" boxes.
3. Fill in "What I did and when I did it."
4. Fill in "My follow-up plan" and "Questions I want to ask."

Have this action plan with you when you talk with your doctors, pharmacists, and other healthcare providers. Share this with your family or caregivers too.

DATE PREPARED: XX/XX/XXXX

What we talked about: SAMPLE	
What I need to do: SAMPLE	**What I did and when I did it:**

What we talked about: SAMPLE	
What I need to do: SAMPLE	**What I did and when I did it:**

My follow-up plan (add notes about next steps):

Questions I want to ask (include topics about medications or therapy):

If you have any questions about your action plan, call <Pharmacist Name> at XXX-XXX-XXXX between the hours of <Pharmacist hours of availability>.

Pharmacy Name
Address
City, St Zip

CareSource®

PERSONAL MEDICATION LIST FOR PATIENT NAME, DOB:XX/XX/XXXX

This medication list was made for you after we talked. We also used information from your prescription claims data.

- Use blank rows to add new medications. Then fill in the dates you started using them.
- Cross out medications when you no longer use them. Then write the date and why you stopped using them.
- Ask your doctors, pharmacists, and other healthcare providers to update this list at every visit.

If you go to the hospital or emergency room, take this list with you. Share this with your family or caregivers too.

Keep this list up-to-date with:

- ☐ prescription medications
- ☐ over the counter drugs
- ☐ herbals
- ☐ vitamins
- ☐ minerals

DATE PREPARED: XX/XX/XXXX

Allergies or side effects:
SAMPLE

Medication: SAMPLE	
How I use it: SAMPLE	
Why I use it: SAMPLE	**Prescriber:** SAMPLE
Notes:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

PERSONAL MEDICATION LIST FOR PATIENT NAME, DOB:XX/XX/XXXX

(Continued)

Medication: SAMPLE	
How I use it: SAMPLE	
Why I use it: SAMPLE	**Prescriber:** SAMPLE
Notes:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication: SAMPLE	
How I use it: SAMPLE	
Why I use it: SAMPLE	**Prescriber:** SAMPLE
Notes:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication: SAMPLE	
How I use it: SAMPLE	
Why I use it: SAMPLE	**Prescriber:** SAMPLE
Notes:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

PERSONAL MEDICATION LIST FOR PATIENT NAME, DOB:XX/XX/XXXX

(Continued)

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
Notes:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
Notes:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
Notes:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

PERSONAL MEDICATION LIST FOR PATIENT NAME, DOB:XX/XX/XXXX

(Continued)

Other Information:

If you have any questions about your medication list, call <Pharmacist Name> at XXX-XXX-XXXX between the hours of <Pharmacist hours of availability>.