Name of Insurer:

Name of Plan:

Consumer Plan Selection Worksheet

(Make multiple copies, as needed)

Questions for Each Part D Plan

Complete this form for each potential plan. For persons with access to the Internet, go to http://www.medicare.gov. Individuals who do not have internet access can call 1-800-MEDICARE (1-800-633-4227). For people who are deaf or hard of hearing, the toll-free TTY line is 1-877-486-2048. To calculate plan premium level, determine if you qualify for *Extra Help*. If you qualify for the full subsidy, see table on page 15 for subsidy level.

Pharmacy Access: What is your preferred pharmacy? _____ Is it in the plan's network? Yes No

Plan Premium Level			Drug Coverage Information					Using Physician Responses	
Monthly Plan Premium *(A)*	***Extra Help* Premium Subsidy** *(B)*	**Individual Monthly Premium** *(C)* *C = A - B*	**Drug Name**	**On Formulary?** *(Circle One)*	**Cost-Sharing**	**Prior Authorization Required?** *(Circle One)*	**Plan Has Quantity Limits?** *(Circle One)*	**Treatment Substitutions Acceptable?** *(Circle One)*	**Physician Special Concerns**
				Yes No		Yes No	Yes No	Yes No	
				Yes No		Yes No	Yes No	Yes No	
				Yes No		Yes No	Yes No	Yes No	
				Yes No		Yes No	Yes No	Yes No	
				Yes No		Yes No	Yes No	Yes No	
				Yes No		Yes No	Yes No	Yes No	
				Yes No		Yes No	Yes No	Yes No	
				Yes No		Yes No	Yes No	Yes No	
				Yes No		Yes No	Yes No	Yes No	
				Total:	**Total $:**	**Total:**	**Total:**	**Total:**	