Date document generated

Member Name
Member Address
Member Address 2
Member city, state and zip code

Dear Salutation Member Name,

Thank you for talking with me on date document generated, about your health and medications. As a follow-up to our conversation, I have included two documents:

1. Your **Recommended To-Do List** has steps you should take to get the best results from your medications.

2. Your **Medication List** will help you keep track of your medications and how to take them.

If you want to talk about these documents, please call Highmark Wholecare at 1-855-845-6212, Monday-Friday 9am-5pm EST. TTY users call 711.

I look forward to working with you and your doctors to make sure your medications work well for you.

Sincerely,

Pharmacist's Signature
Pharmacist's Printed Name
Title, Encounter Location Name

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB number for this information collection is 0938-1154. The time required to complete this information collection is estimated to average 40 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Recommended To-Do List

Prepared on: MM/DD/YYYY

You can get the best results from your medications by completing the items on this **"To-Do List."**

Bring your **To-Do List** when you go to your doctor. And, share it with your family or caregivers.

My To-Do List

What we talked about:	**What I should do:** ❑ ❑ ❑
What we talked about:	**What I should do:** ❑ ❑ ❑

How to Safely Dispose of Unused Prescription Medications

Prepared on: MM/DD/YYYY

Get rid of unused or expired medicine as soon as possible. Read the information that came with your medicine. It might tell you how to safely get rid of it. If you don't have the information, follow one of these safe options:

1. **Ask your local pharmacy** if they have a program to get rid of medicine you do not need anymore.
   - Some pharmacies (and other DEA approved sites) allow medicine to be mailed to the pharmacy.
   - Ask for the special packages needed to mail medicine.
2. Bring the medicine to a **community Drug Take Back program**.
   - This is the best method for controlled substances.
   - Drug Take Back programs near you:
     - Location 1 Name
       Location 1 Address
     - Location 2 Name
       Location 2 Address
3. Visit **DEATakeBack.com** to find other collection sites in your area. You can search by your city or zip code at https://apps2.deadiversion.usdoj.gov/pubdispsearch/spring/main?execution=e2s1.
4. Follow the steps below to **throw away medicine in the trash** or flush approved medications. Do not flush medicine in the toilet or sink unless there are instructions telling you to do so. Learn more about the flush list and safe medicine disposal at https://www.hhs.gov/opioids/prevention/safely-dispose-drugs/index.html.

Take or scratch off personal information, including Rx number, from the packaging before getting rid of medicine.

Throwing away medicine at home

There are three simple steps to throw away your medicine in your household trash:

1. **Remove** the medicine from its container and **mix** with an unappealing substance, such as dirt, used coffee grounds or kitty litter.
2. Put in **sealable bag** or other container. This will prevent leaking or breaking out of the garbage bag.
3. Place in the trash.

Medication List

Prepared on: MM/DD/YYYY

Bring your Medication List when you go to the doctor, hospital, or emergency room. And, share it with your family or caregivers.

Note any changes to how you take your medications. Cross out medications when you no longer use them.

Medication	How I take it	Why I use it	Prescriber
Medication Name, Strength, Form	Directions for use	diagnosis/indication	Prescriber Name
Medication Name, Strength, Form	Directions for use	diagnosis/indication	Prescriber Name
Medication Name, Strength, Form	Directions for use	diagnosis/indication	Prescriber Name

Add new medications, over-the-counter drugs, herbals, vitamins, or minerals in the blank rows below.

Medication	How I take it	Why I use it	Prescriber
Medication Name, Strength, Form	Directions for use	diagnosis/indication	Prescriber Name
Medication Name, Strength, Form	Directions for use	diagnosis/indication	Prescriber Name
Medication Name, Strength, Form	Directions for use	diagnosis/indication	Prescriber Name

Allergies:

Insert Allergies

Side effects I have had:

Insert Side Effects

My notes and questions:

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