< MTM PROVIDER HEADER or OPTIONAL LOGO >

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<Date>

<Beneficiary Name>
<Street Address>
<City, State, Zip>

{ Additional space for optional plan/provider use, such as barcodes, document reference numbers, beneficiary identifiers, case numbers or title of document }

Dear <Beneficiary Name>:

Thank you for talking with me on < Month Day, Year > about your health and medications. Medicare's MTM (Medication Therapy Management) program helps you understand your medications and use them safely.

This letter includes an action plan (Medication Action Plan) and 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 health care providers in your care team.
- Ask your doctors, pharmacists, and other healthcare providers to update the action plan and medication list 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 <the Medication Management Center toll free at 1-844-866-3735, M-F, 10am-8pm, Eastern (TTY/TDD 1-800-367-8939)>. We look forward to working with you, your doctors, and other healthcare providers to help you stay healthy through the <plan name / client name> MTM program.

Sincerely,

<Pharmacist Signature>

<Pharmacist Name, Pharmacist>

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MEDICATION ACTION PLAN FOR < *Insert Member's name*, DOB: *mm/dd/yyyy* >

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 in your care team. Share this with your family or caregivers too.

DATE PREPARED: < *INSERT DATE* >

What we talked about: [< *Insert description of topic* >]	
What I need to do: [< *Insert recommendations for beneficiary activities* >]	**What I did and when I did it:** { *Leave blank for beneficiary's notes* }

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

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

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

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

My follow-up plan (add notes about next steps)**:**
{*Leave blank for beneficiary's notes* }

Questions I want to ask (include topics about medications or therapy)**:**
{*Leave blank for beneficiary's notes* }

If you have any questions about your action plan, call <the Medication Management Center toll free at 1-844-866-3735, Monday through Friday, 10 a.m. to 8 p.m. Eastern, TTY/TDD users, please call 1-800-367-8939>.

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PERSONAL MEDICATION LIST FOR < *Insert Member's name*, DOB: *mm/dd/yyyy* >

This medication list was made for you after we talked. We also used information from < *insert sources of information* >.

- 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 in your care team to update this list at every visit.

Keep this list up-to-date with:

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

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

DATE PREPARED: < *INSERT DATE* >

Allergies or side effects: [< *Insert beneficiary's allergies and adverse drug reactions including the medications and their effects* >]

Medication: [< *Insert generic name and brand name, strength, and dosage form for current/active medications.* >]	
How I use it: [< *Insert regimen, including strength, dose and frequency (e.g., 1 tablet (20 mg) by mouth daily), use of related devices and supplemental instructions as appropriate* >]	
Why I use it: [< *Insert indication or intended medical use* >]	**Prescriber:** [< *Insert prescriber's name* >]
***{ Insert other title(s) or delete this field* :** *Use for optional product-related information, such as additional instructions, product image/identifiers, goals of therapy, pharmacy, etc., and change field title accordingly. This field may be expanded or divided. Delete this field if not used. }*	
Date I started using it: [< *May be estimated by Plan or entered based upon beneficiary-reported data, or leave blank for beneficiary to enter start date* >]	**Date I stopped using it:** {*Leave blank for beneficiary to enter stop date* }
Why I stopped using it: { *Leave blank for beneficiary's notes* }	

PERSONAL MEDICATION LIST FOR < *Insert Member's name*, DOB: *mm/dd/yyyy* > (Continued)	
Medication:	
How I use it:	
Why I use it:	**Prescriber:**
{ ***Insert other title(s) or delete this field*** }	
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:**
{***Insert other title(s) or delete this field*** }	
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:**
{ ***Insert other title(s) or delete this field*** }	
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:**
{***Insert other title(s) or delete this field*** }	
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:**
{ ***Insert other title(s) or delete this field*** }	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

PERSONAL MEDICATION LIST FOR < *Insert Member's name*, DOB: *mm/dd/yyyy* > (Continued)	
Medication:	
How I use it:	
Why I use it:	**Prescriber:**
{Insert other title(s) or delete this field }	
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:**
{ Insert other title(s) or delete this field }	
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:**
{Insert other title(s) or delete this field }	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Other Information:

If you have any questions about your medication list, call < *insert MTM provider contact information, phone numbers, days/times, etc.* >.

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