

|                                   |             |
|-----------------------------------|-------------|
| <b>MEDICATION ACTION PLAN FOR</b> | <b>DOB:</b> |
|-----------------------------------|-------------|

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:**

|                              |                                      |
|------------------------------|--------------------------------------|
| <b>What we talked about:</b> |                                      |
| <b>What I need to do:</b>    | <b>What I did and when I did it:</b> |

|                              |                                      |
|------------------------------|--------------------------------------|
| <b>What we talked about:</b> |                                      |
| <b>What I need to do:</b>    | <b>What I did and when I did it:</b> |

|                              |                                      |
|------------------------------|--------------------------------------|
| <b>What we talked about:</b> |                                      |
| <b>What I need to do:</b>    | <b>What I did and when I did it:</b> |

|                              |                                      |
|------------------------------|--------------------------------------|
| <b>What we talked about:</b> |                                      |
| <b>What I need to do:</b>    | <b>What I did and when I did it:</b> |

|                              |                                      |
|------------------------------|--------------------------------------|
| <b>What we talked about:</b> |                                      |
| <b>What I need to do:</b>    | <b>What I did and when I did it:</b> |

|  |
|--|
| <b>My follow-up plan (add notes about next steps):</b> |
|--|

|   |
|---|
| <b>Questions I want to ask (include topics about medications or therapy):</b> |
|---|

If you have any questions about your action plan, call call OptumRx® 1-866-352-5305, TTY 711 8 a.m. - 8 p.m. CST, Monday-Friday.