

**SELF-FUNDED PLAN**

**MEDICATION TRANSITION**

**FORM**

Welcome to Florida Health Care Plans. The following form is part of the Medication Transition Program for our new Members. Our Medication Transition Program is a service that is offered to members who are new to Florida Health Care Plans and take medications that are not covered by the plan (non-formulary). This helps members get the best value for their health care benefit by using medications that the self-funded plan covers.

Non-formulary medications can cost members 3 to 20 times as much as a similar formulary medication. If you would like to know if we can help reduce your medication costs for uncovered drugs, please complete this Medication Transition Form. Afterwards, return it with the pre-addressed envelope or bring it to one of the Florida Health Care Pharmacies. Your form will be reviewed by al Pharmacist who will suggest a similar medication to the physician you indicated on the form.

Please fill out the form completely, and be sure to include all medications you currently take. There are also sections for medications you are allergic to as well as medications you cannot take due to side effects. If you have tried medications that were not effective for you in the past, please put that information in the miscellaneous section of the form. This will help the pharmacist recommend a medication that doesn’t interact with the other drugs you take, as well as one that is similar in effectiveness to the non-formulary drug it is replacing.

After your Medication Transition Form is reviewed by the pharmacist, a substitution request will be sent to the physician you indicated on the form. If the physician is in agreement with the recommendation, a prescription will be sent to the pharmacy you chose on the form. If you take more than one non-formulary drug, we will try to find a similar covered drug for each.

Not all medications are appropriate to substitute, so there may be some cases where the pharmacist will not make a recommendation to your physician.

We appreciate your membership and look forward to serving you. Thank you, and welcome to Florida

Health Care Plans!

David Fox, PharmD

Clinical Pharmacy Director

Florida Health Care Plans

03-310-35 07-10-13 01-26-16

FHCP 27-230 - 11/06P FHCP 47 - Rev. 11/

**Self-Funded Medication Transition Program**

Medical Record #: Today’s Date: / / 20

Members Name (Please Print): FIRST LAST

Date of Birth (Month/Day/Year): Phone Number: ( )

Weight: (in pounds) Height: (feet', inches", example: 5'6") Sex:  M  F

Primary Care Physician (PCP):

PCP Phone #: ( )

**FHCP PHARMACIES: *(Please check which pharmacy you will use)***

 ***Florida Health Care Plan, Inc.***

350 N. Clyde Morris Boulevard, Daytona Beach

386-248-0832 or 1-800-321-1227

Monday through Friday, 8:30 a.m. – 6:00 p.m.; Closed Saturday and Sunday

 ***Florida Health Care Plan, Inc.***

939 N. Spring Garden Avenue, DeLand

386-736-7318

Monday through Friday, 8:30 a.m. – 6:00 p.m.; Saturday, 9:00 a.m. – 1:00 p.m.; Closed Sunday

 ***Florida Health Care Plan, Inc.***

239 N. Ridgewood Avenue, Edgewater

386-423-4212

Monday through Friday, 8:30 a.m. – 6:00 p.m.; Saturday, 9:00 a.m. – 1:00 p.m.; Closed Sunday

 ***Florida Health Care Plan, Inc.***

1340 Ridgewood Avenue, Holly Hill

386-676-7120 or 1-800-232-0216

Monday through Friday, 8:30 a.m. – 6:00 p.m.; Saturday, 9:00 a.m. – 5:00 p.m.; Closed Sunday

***Florida Health Care Plan, Inc.***

1021 S. Washington Avenue, Titusville

321-567-7500

Monday through Friday, 8:30 a.m. – 6:00 p.m.; Saturday, 9:00 a.m. – 1:00 p.m.; Closed Sunday

***Florida Health Care Plan, Inc.***

785 N. Wickham Road, Suite 104, Melbourne

321-567-7505

Monday through Friday, 8:30 a.m. – 6:00 p.m.; Saturday, 9:00 a.m. – 1:00 p.m.; Closed Sunday

***Florida Health Care Plan, Inc.***

145 City Place, Suite 100, Palm Coast

386-302-0977

Monday through Friday, 8:30 a.m. – 6:00 p.m.; Saturday, 9:00 a.m. –1:00 p.m.; Closed Sunday

 ***Florida Health Care Plan, Inc.***

2777 Enterprise Road, Orange City

386-774-5961 or 1-800-390-3427

Monday through Friday, 8:30 a.m. – 6:00 p.m.; Saturday, 9:00 a.m. – 1:00 p.m.; Closed Sunday

 ***Florida Health Care Plan, Inc.***

309 Palm Coast Parkway, Palm Coast

386-446-9447

Monday through Friday, 8:30 a.m. – 6:00 p.m.; Saturday, 9:00 a.m. – 1:00 p.m.; Closed Sunday

 ***Florida Health Care Plan, Inc.***

740 Dunlawton Avenue, Suite 150, Port Orange

386-767-0563

Monday through Friday, 8:30 a.m. – 6:00 p.m.; Saturday, 9:00 a.m. – 1:00 p.m.; Closed Sunday

***Florida Health Care Plan, Inc.***

4932 W State Road 46, Suite 1000, Sanford

407-732-7950

Monday through Friday, 8:30 a.m. – 6:00 p.m.; Saturday, 9:00 a.m. – 1:00 p.m.; Closed Sunday

***Florida Health Care Plan, Inc.***

1954 Rockledge Blvd., Suite 107, Rockledge

321-567-7503

Monday through Friday, 8:30 a.m. – 6:00 p.m.; Saturday, 9:00 a.m. – 5:00 p.m.; Closed Sunday

***Florida Health Care Plan, Inc.***

200 Southpark Blvd., Suite 206, St Augustine

Phone TBD

Monday through Friday, 8:30 a.m. – 6:00 p.m.; Saturday, 9:00 a.m. –1:00 p.m.; Closed Sunday

**1) MEDICATION ALLERGIES:**

Please list the names of any medications that you are allergic to, or write ‘NONE KNOWN’ below. Allergies generally will give people a rash, swelling of the lips or throat, itching, or severe skin reactions.

**NAME of MEDICATION WHY YOU CANNOT TAKE THIS MEDICATION**

**2) MEDICATION YOU CANNOT TAKE DUE TO SIDE EFFECTS OR MEDICAL PROBLEMS:** Please list the medication and the reason you cannot take the drug. Please write “NONE KNOWN” if not applicable. **Examples: Nausea, Stomach ache, Headache, Muscle ache**

**NAME of MEDICATION WHY YOU CANNOT TAKE THIS MEDICATION**

***Example:*** Ibuprofen Stomach Ulcer/ Stomach ache

**3) MEDICATIONS YOU CURRENTLY TAKE:**

Please fill in the table below: Include any herbal or over the counter medications you **take every day or on a regular basis**.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Drug name*** | ***Strength***  ***(MG)*** | ***Directions*** | ***How long on medication*** | ***What the medication is used for*** | ***No substitution requested*** |
| ***Example:*** Synthroid | 0.075 | 1 pill a day | 3 months | Thyroid | *Check this box for meds you do not wish to substitute* |
| ***Example:*** Metformin | 500 | 2 pills 2 times a day | 5 years | Diabetes |
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**4) MISCELLANEOUS INFORMATION**

Please list any medical conditions you have that are NOT being treated with medications listed above. Example: Headaches, Cataracts

**Miscellaneous:** If there is anything in addition you would like the pharmacist to know while reviewing your medications, please write it below. Include any drugs which were ineffective for you.