St. Vincent de Paul Pharmacy

Date/*Fecha* ______________

PATIENT INFORMATION – *Información del Paciente*

Last Name ______________________ **First Name** ______________________ **Initial** ________
Apellido *Nombre* *Inicial*

Address ____
Dirección Street #/*número de la casa* Street name /*nombre de la calle* Unit # /*apartamento* City /*ciudad* County/ State / *Estado* Zip

Phone ________________ **# of people in your household** ________ **Gender** ☐ Male ☐ Female
Teléfono *Número de personas que habitan con usted* *Géner* *Masculino* *Femenino*

Social Security # ______________ **Date of Birth (mm/dd/yyyy)** ____________
Número de Seguro Social *Fecha de Nacimiento*

Age Range of Client ☐ 0-17 ☐ 18-29 ☐ 30-49 ☐ 50-64 ☐ 65+
Rango de edad del cliente:

Race/Ethnicity ☐ African American ☐ Asian ☐ Hispanic ☐ Native American ☐ White ☐ Other ____________
Raza / Etnicidad *Afroamericano* *Asiático* *Hispano* *Nativo americano* *Caucásico* *Otro*

Primary Language ______________ **Interpreter Needed?** ☐ Yes ☐ No **Highest grade completed** ________
Idioma Principal *¿Necesita interprete?* *Sí* *No* *Último nivel de escolaridad*

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Estado Civil *Soltero* *Casado* *Separado* *Divorciado* *Viudo*

Employment ☐ Full Time ☐ Part Time ☐ Temp ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student ☐ Other ________
Empleo *Tiempo Completo* *Medio Tiempo* *Temporal* *Desempleado* *Jubilado* *Discapacitado* *Estudiante* *Otro*

Are you a Veteran? ☐ Yes ☐ No **Is your spouse a veteran?** ☐ Yes ☐ No
¿Eres usted un Veterano? *Sí* *No* *¿Es su conyuge un veterano?* *Sí* *No*

Do you have a Case Manager? ☐ Yes ☐ No **If yes, Name and Organization** ______________________
¿Tienes un administrador de casos? *Sí* *No* *En caso afirmativo, Nombre y Organización*

Health Insurance : ☐ Medicare ☐ Medicaid ☐ VA Benefits ☐ Parkland Financial Assistance ☐ Other ____________ ☐ None
Seguro Médico: *Medicare* *Medicaid* *Beneficios Veterano* *Plan de Asistencia Parkland* *Otro* *Nada*

Please list any allergies to medications and your reaction ______________________________
____

In the last 6 months, have you been admitted to the hospital or visited an emergency room for your condition?
En los últimos 6 meses, ¿ha sido admitido usted al hospital o ha visitado una sala de emergencia por su condición?

☐ Yes ☐ No **If yes, how many times?** __________

SPOUSE INFORMATION (If applicable) – *Información del cónyuge (si aplica)*

Last Name ______________________ **First Name** ______________________ **Initial** ________
Apellido *Nombre* *Inicial*

Social Security # ______________ **Date of Birth (mm/dd/yyyy)** ______________ **Gender** ☐ Male ☐ Female
Número de Seguro Social *Fecha de Nacimiento* *Género* *Masculino* *Femenino*

Employment ☐ Full Time ☐ Part Time ☐ Temp ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student ☐ Other ________
Empleo *Tiempo Completo* *Medio Tiempo* *Temporal* *Desempleado* *Jubilado* *Discapacitado* *Estudiante* *Otro*

(Please continue on other side/*termina en el otro lado*)

OTHER HOUSEHOLD MEMBERS - *Otros miembros del hogar (si aplica)*

	Name *Nombre Completo*	Date of Birth *Fecha de Nacimiento*	Relationship *Relación*	Grade Level *Nivel de escolaridad*	Gender *Género*	Veteran *¿Veterano*
1)						
2)						
3)						
4)						
5)						

The information below is not required for service at St. Vincent de Paul Pharmacy, but may help us get you the medication you need from pharmaceutical companies' patient assistance programs:

U.S. Citizen ☐ Yes ☐ No **U.S. Resident** ☐ Yes ☐ No

(Note: A "U.S. Resident" or "green card" holder, is a non-U.S. Citizen who is authorized to reside in the US)

La información que se le pide a continuación no es requisito para recibir servicio en la farmacia, pero puede ayudarnos a obtener los medicamentos que usted necesita de los programas de asistencia al paciente de las compañías farmacéuticas cuales solicitamos:

Ciudadano de USA ☐ Si ☐ No **Residente de USA** ☐ Si ☐ No

(Nota: "Ciudadano de USA" o una persona que posee "Green-Card" es un ciudadano de otro país autorizado a residir en US.)

AGENT AUTHORIZATION FOR TRANSPORT OF DOCUMENTS

I authorize the person listed below to transport this information to SVdP Pharmacy for the purpose of submitting my application for service. I understand that this person does not work for SVdP Pharmacy and is completing this task on a volunteer basis. This person may transport my documents to the pharmacy, but will not be involved in the process of qualifying me for service.

AUTORIZACIÓN PARA EL TRANSPORTE DE DOCUMENTOS

Yo autorizo a la persona mencionado a continuación para que transmita esta información a la farmacia SVdP Pharmacy con el fin de enviar mi solicitud de servicio. Entiendo que esta persona no trabaja para SVdP Pharmacy y que está cumpliendo esta tarea de forma voluntaria. Esta persona puede transportar mis documentos a la farmacia, pero que no participará en el proceso de calificarme para el servicio.

Patient Signature ______________________ **Date** ____________
Firma de Paciente *Fecha*

Agent Name ______________________
Nombre de Agente

Agent Signature ______________________ **Date** ____________
Firma de Agente *Fecha*

Self-Declaration of Income

This form is to be used only for Applicants who do not earn enough income to file taxes or who provide services where it is not feasible to obtain a letter from each individual they receive reimbursement from. This statement form must be completed by the Enrollment Worker/Case Manager and signed by the patient. If applicable, IRS form 4506-T should be completed, signed by the client, and attached.

Applicant Name: ____
Last **First** **MI**

Address:
Street **City** **State** **Zip Code**

Telephone: ____________________ **Date of Birth:** ____________________

Employment Information (if employed)

Type of Work Performed: **Average Number of Days Worked Weekly:** ______

Average Daily Income: ______ **Average Wkly Income:** ______ **Average Monthly Income:** ______

Total Monthly Household Income: ____________________

Monthly Expenses

Rent/Mortgage		Transportation	
Electricity		Insurance	
Water		Entertainment	
Gas/Oil/Propane		Credit Card Payment	
Telephone		Cable	
Food		Loan Repayments	
Clothing		Miscellaneous	
Car Payment			

Total Monthly Expenses: ____________________

If Monthly Expenses exceed reported Monthly Household Income, Applicant needs to detail all sources of income and resources used to meet on-going Monthly expenses. Request copies of bank statements, if available to verify.

Source	Amount	Source	Amount

Applicant:

By my signature below, I attest that the information provided is accurate, complete, and true to the best of my knowledge and belief. I acknowledge that any omission or inaccurate information could jeopardize my request for assistance through the ______________________________ program.

______________________________ ____________________
Applicant Signature **Date**

Case Manager/Enrollment Worker: ______________________________

Consent to Treatment by Volunteers
Consentimiento a Recibir Tratamiento por Voluntarios

I understand that services I receive from St. Vincent de Paul Pharmacy may be provided by a volunteer who is providing care that is not administered for or in expectation of compensation.

I further understand that Texas Law imposes limits on the recovery of damages from such a volunteer in exchange for receiving health care services. Those limitations include immunity from civil liability for any act or omission resulting in death or injury to a patient if:

1) The volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization.
2) The volunteer commits the act or omission in the course of providing health care services to the patient.

I acknowledge that the health care providers, as volunteers, are providing me with care that is not administered for expectation of compensation, and in exchange for receiving the health care services, recovery of damages is limited.

Entiendo que los servicios recibidos por St. Vincent de Paul Pharmacy podrán ser prestados por un voluntario que esté prestando atenciones que no sean proveídas por o en espera de recibir compensación.

Entiendo, además, que la Ley de Texas impone límites en la recuperación por daños de cualquier voluntario a cambio de recibir servicios de salud. Dichas limitaciones incluyen inmunidad a responsabilidad civil por cualquier acto u omisión que resultare en muerte o daño a un paciente si:

1) El voluntario estaba actuando en buena fe en el curso y durante el alcance de sus responsabilidades y funciones en la organización.
2) El voluntario comete un acto u omisión mientras se encontraba prestando servicios de salud al paciente.

Reconozco que los proveedores de servicios de salud, en calidad de voluntarios, están brindándome servicios de salud que no son prestados a cambio de la expectativa de recibir remuneración, y a cambio de recibir los servicios de salud, la recuperación por daños queda limitada.

( ) Myself – *Yo Mismo*

( ) The following person for whom I am legally responsible: ______________________________
La persona detallada a continuación, por quien soy legalmente responsable

Patient's Name Print ______________________________ Date ______________
Nombre del paciente imprimir *Fecha*

Patient's Signature ______________________________ Date ______________
(Or Signature of legal guardian) *Firma del paciente (o Firma del guardián legal)* *Fecha*

Witness' Signature ______________________________ Date ______________
Firma del examinador *Fecha*

Terms of Service

My initials indicate that I have read, understand and agree to each statement.

________ **Terms of Qualification for Service**

I acknowledge that the terms concerning qualification for service at St. Vincent de Paul Pharmacy have been explained to me and I understand them. I also understand that I have been certified for up to twelve (12) months, and I understand that re-verification of qualification for service at the Pharmacy is needed to continue receiving medications beyond that date.

________ **Change of Information Agreement**

I attest to the above information as true to the best of my knowledge, and will report any change of my address, my insurance status or income to SVdP Pharmacy immediately. I understand that any of these changes may affect my qualification for service at the pharmacy.

________ **Consent and Release**

I understand that any information I provide to SVdP Pharmacy will be kept confidential. However, I hereby authorize SVdP Pharmacy to share my information, including but not limited to my name, address and other personal information with other medical facilities and/or pharmaceutical manufacturers participating in my care in order to coordinate services. I also authorize SVdP Pharmacy to share my information, including eligibility and prescription records, with any Pharmaceutical Manufacturers Patient Assistance Program(s), or their designee, for which I qualify, for auditing purposes. I understand that this consent is authorized for twelve (12) months from the date signed below, and that I may revoke this consent at any time by submitting a request in writing to SVdP Pharmacy, except when action has already been taken to obtain and/or release such information.

________ **Permission to Release Information for Patient Assistance Program Qualification**

I also authorize St. Vincent de Paul Pharmacy to use my information, including prescription records, to assist me in finding any Patient Assistance Program(s) for which I qualify, in order to assist me in accessing these programs, and to coordinate services.

By my signature, I indicate that I agree overall to the terms and conditions of service at St. Vincent de Paul Pharmacy. If the patient is a child under the age of 18, I sign as their legal guardian.

Patient's Name Print ______________________________ **Date** __________

Patient's Signature ______________________________ **Date** __________

Guardian's Signature ______________________________ **Date** __________
(if patient is under the age Of 18)

Términos de Servicio

Mis iniciales indican que he leído, entiendo y estoy de acuerdo con cada afirmación.

___________ **Términos para calificar para el servicio**

Reconozco que los términos relativos a calificar para recibir servicio en St. Vincent de Paul Pharmacy se me han sido explicados y los entiendo. También entiendo que he sido certificado para un periodo de doce (12) meses, y entiendo que se necesitara volver a verificar si califico para recibir servicio en la Farmacia después de esa fecha si gusto seguir recibiendo medicamentos.

___________ **Acuerdo de Cambio de Información**

Atestiguo que la información que presente es verdadera a lo mejor de mi conocimiento y inmediatamente informaré a SVdP Pharmacy de cualquier cambio de dirección, cambio de estado de mi seguro, o nuevo ingreso financiero que reciba. Entiendo que cualquiera de estos cambios puede afectar si sigo calificando para el servicio en la farmacia o no.

___________ **Consentimiento y Descargo de Responsabilidad**

Entiendo que cualquier información que proporcione a SVdP Pharmacy se mantendrá confidencial. Sin embargo, autorizo a SVdP Pharmacy el poder de compartir mi información, que incluye pero no se limita a mi nombre, dirección y otra información personal, con otras instalaciones médicas y / o fabricantes de productos farmacéuticos que participan en mi cuidado para coordinar mis servicios. También autorizo a SVdP Pharmacy para que comparta mi información, incluyendo los registros de elegibilidad y prescripción, con cualquier Pharmaceutical Manufacturers Patient Assistance Program(s), o la persona designada por ellos, para cual califico, con fines de auditoría. Entiendo que este consentimiento está autorizado para un periodo de doce (12) meses a partir de la fecha en que se firma esta pagina, y que puedo revocar este consentimiento en cualquier momento enviando una solicitud por escrito a SVdP Pharmacy, excepto cuando ya se hayan tomado medidas para obtener y / o liberar tal información.

___________ **Permiso para Divulgar Información para ver si Califico para Programas de Asistencia al Paciente**

También autorizo a que St. Vincent de Paul Pharmacy use mi información, incluyendo los registros de recetas, para ayudarme a encontrar cualquier Programa de Asistencia al Paciente a cual califique, a fin de ayudarme a acceder a estos programas y para coordinar mis servicios.

Con mi firma, indico que estoy de acuerdo en general con los términos y condiciones de servicio en la farmacia St. Vincent de Paul Pharmacy. Si el paciente es menor de 18 años, firmo como su guardian legal.

Nombre del Paciente: __________________________________ **Fecha** ______________

Firma del Paciente: __________________________________ **Fecha:** ______________

Firma del Guardian __________________________________ **Fecha** ______________

(si el paciente es menor de 18 años de edad)

St. Vincent de Paul Pharmacy Inventory List

Drug Name	Therapeutic Class Description
SULFAMETHOXAZOLE-TMP DS TABLET	ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS
LISINOPRIL-HCTZ 20-12.5 MG TAB	ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC
LISINOPRIL-HCTZ 20-25 MG TAB	ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC
CARVEDILOL 12.5 MG TABLET	ALPHA/BETA-ADRENERGIC BLOCKING AGENTS
CARVEDILOL 25 MG TABLET	ALPHA/BETA-ADRENERGIC BLOCKING AGENTS
CARVEDILOL 3.125 MG TABLET	ALPHA/BETA-ADRENERGIC BLOCKING AGENTS
CARVEDILOL 6.25 MG TABLET	ALPHA/BETA-ADRENERGIC BLOCKING AGENTS
MIRTAZAPINE 30 MG TABLET	ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS
DOXAZOSIN MESYLATE 4 MG TAB	ALPHA-ADRENERGIC BLOCKING AGENTS
DOXAZOSIN MESYLATE 4 MG TAB	ALPHA-ADRENERGIC BLOCKING AGENTS
ENTRESTO 97 MG-103 MG TABLET	ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB(ARNI)
ENTRESTO 24 MG-26 MG TABLET	ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB(ARNI)
ENTRESTO 49 MG-51 MG TABLET	ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB(ARNI)
BUSPIRONE HCL 10 MG TABLET	ANTI-ANXIETY DRUGS
ATROVENT 17 MCG HFA INHALER	ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING
DICYCLOMINE 20 MG TABLET	ANTICHOLINERGICS/ANTISPASMODICS
DICYCLOMINE 20 MG TABLET	ANTICHOLINERGICS/ANTISPASMODICS
TRILEPTAL 300 MG TABLET	ANTICONVULSANTS
TEGRETOL XR 400 MG TABLET	ANTICONVULSANTS
GABAPENTIN 600 MG TABLET	ANTICONVULSANTS
DIVALPROEX SOD ER 250 MG TAB	ANTICONVULSANTS
TRILEPTAL 150 MG TABLET	ANTICONVULSANTS
TEGRETOL XR 200 MG TABLET	ANTICONVULSANTS
DIVALPROEX SOD ER 500 MG TAB	ANTICONVULSANTS
TEGRETOL XR 100 MG TABLET	ANTICONVULSANTS
LEVETIRACETAM 1,000 MG TABLET	ANTICONVULSANTS
LEVETIRACETAM 500 MG/5 ML VIAL	ANTICONVULSANTS
GABAPENTIN 800 MG TABLET	ANTICONVULSANTS
TRILEPTAL 600 MG TABLET	ANTICONVULSANTS
LAMOTRIGINE 100 MG TABLET	ANTICONVULSANTS
LOPERAMIDE 2 MG CAPSULE	ANTIDIARRHEALS
ONDANSETRON HCL 8 MG TABLET	ANTIEMETIC/ANTIVERTIGO AGENTS
EMEND 80 MG CAPSULE	ANTIEMETIC/ANTIVERTIGO AGENTS
ONDANSETRON HCL 4 MG TABLET	ANTIEMETIC/ANTIVERTIGO AGENTS
SPORANOX 100 MG CAPSULE	ANTIFUNGAL AGENTS
FLUCONAZOLE 100 MG TABLET	ANTIFUNGAL AGENTS
PHARBEDRYL 25 MG CAPSULE	ANTIHISTAMINES - 1ST GENERATION
FEXOFENADINE HCL 180 MG TABLET	ANTIHISTAMINES - 2ND GENERATION
CETIRIZINE HCL 10 MG TABLET	ANTIHISTAMINES - 2ND GENERATION
LORATADINE ALLERGY 5 MG/5 ML	ANTIHISTAMINES - 2ND GENERATION
INVOKANA 100 MG TABLET	ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2)INHIB
INVOKANA 300 MG TABLET	ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2)INHIB

JARDIANCE 25 MG TABLET	ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2)INHIB
JARDIANCE 10 MG TABLET	ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2)INHIB
METFORMIN HCL 1,000 MG TABLET	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE
METFORMIN HCL 500 MG TABLET	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE
METFORMIN HCL 850 MG TABLET	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE
METFORMIN HCL ER 500 MG TABLET	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE
JANUVIA 25 MG TABLET	ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS
JANUVIA 50 MG TABLET	ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS
JANUVIA 100 MG TABLET	ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS
GLIMEPIRIDE 2 MG TABLET	ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE
GLIPIZIDE 10 MG TABLET	ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE
GLIMEPIRIDE 4 MG TABLET	ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE
GLIMEPIRIDE 2 MG TABLET	ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE
GLIPIZIDE 5 MG TABLET	ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE
JANUMET XR 50-500 MG TABLET	ANTIHYPERGLYCEMIC,DPP-4 INHIBITOR-BIGUANIDE COMBS.
JANUMET XR 50-1,000 MG TABLET	ANTIHYPERGLYCEMIC,DPP-4 INHIBITOR-BIGUANIDE COMBS.
JANUMET XR 100-1,000 MG TABLET	ANTIHYPERGLYCEMIC,DPP-4 INHIBITOR-BIGUANIDE COMBS.
JANUMET XR 50-1,000 MG TABLET	ANTIHYPERGLYCEMIC,DPP-4 INHIBITOR-BIGUANIDE COMBS.
PIOGLITAZONE HCL 30 MG TABLET	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE(PPARG AGONIST)
PIOGLITAZONE HCL 30 MG TABLET	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE(PPARG AGONIST)
PIOGLITAZONE HCL 30 MG TABLET	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE(PPARG AGONIST)
INVOKAMET XR 50-500 MG TABLET	ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.
INVOKAMET XR 150-1,000 MG TAB	ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.
INVOKAMET 150-500 MG TABLET	ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.
INVOKAMET 50-500 MG TABLET	ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.
INVOKAMET 50-1,000 MG TABLET	ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.
INVOKAMET XR 150-500 MG TABLET	ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.
INVOKAMET XR 50-1,000 MG TAB	ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.
VYTORIN 10-10 MG TABLET	ANTIHYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB
VYTORIN 10-20 MG TABLET	ANTIHYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB
SIMVASTATIN 10 MG TABLET	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)
PRAVASTATIN SODIUM 40 MG TAB	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)
ATORVASTATIN 10 MG TABLET	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)
ATORVASTATIN 20 MG TABLET	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)
SIMVASTATIN 40 MG TABLET	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)
ATORVASTATIN 40 MG TABLET	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)
PRAVASTATIN SODIUM 20 MG TAB	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)
SIMVASTATIN 20 MG TABLET	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)
PRAVASTATIN SODIUM 40 MG TAB	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)
LISINOPRIL 20 MG TABLET	ANTIHYPERTENSIVES, ACE INHIBITORS
LISINOPRIL 40 MG TABLET	ANTIHYPERTENSIVES, ACE INHIBITORS
LISINOPRIL 2.5 MG TABLET	ANTIHYPERTENSIVES, ACE INHIBITORS
LISINOPRIL 10 MG TABLET	ANTIHYPERTENSIVES, ACE INHIBITORS
LISINOPRIL 30 MG TABLET	ANTIHYPERTENSIVES, ACE INHIBITORS
TELMISARTAN 40 MG TABLET	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST
CLONIDINE HCL 0.1 MG TABLET	ANTIHYPERTENSIVES, SYMPATHOLYTIC
CLONIDINE HCL 0.3 MG TABLET	ANTIHYPERTENSIVES, SYMPATHOLYTIC

CLONIDINE HCL 0.2 MG TABLET	ANTIHYPERTENSIVES, SYMPATHOLYTIC
HYDRALAZINE 25 MG TABLET	ANTIHYPERTENSIVES, VASODILATORS
HYDRALAZINE 50 MG TABLET	ANTIHYPERTENSIVES, VASODILATORS
HYDROXYCHLOROQUINE 200 MG TAB	ANTIMALARIAL DRUGS
MAXALT 10 MG TABLET	ANTIMIGRAINE PREPARATIONS
MAXALT MLT 10 MG TABLET	ANTIMIGRAINE PREPARATIONS
METHOTREXATE 2.5 MG TABLET	ANTINEOPLASTIC - ANTIMETABOLITES
ZYPREXA 15 MG TABLET	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST
OLANZAPINE ODT 10 MG TABLET	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST
PALIPERIDONE ER 3 MG TABLET	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST
ZYPREXA 7.5 MG TABLET	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST
ZYPREXA 5 MG TABLET	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST
RISPERIDONE 1 MG TABLET	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST
OLANZAPINE ODT 5 MG TABLET	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST
PALIPERIDONE ER 6 MG TABLET	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST
QUETIAPINE ER 300 MG TABLET	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST
OLANZAPINE ODT 5 MG TABLET	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST
ARIPIPRAZOLE 5 MG TABLET	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED
ARIPIPRAZOLE 15 MG TABLET	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED
SUCRALFATE 1 GM TABLET	ANTI-ULCER PREPARATIONS
OSELTAMIVIR PHOS 75 MG CAPSULE	ANTIVIRALS, GENERAL
VALACYCLOVIR HCL 1 GRAM TABLET	ANTIVIRALS, GENERAL
VALACYCLOVIR HCL 1 GRAM TABLET	ANTIVIRALS, GENERAL
VALACYCLOVIR HCL 500 MG TABLET	ANTIVIRALS, GENERAL
FINASTERIDE 5 MG TABLET	BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS
TAMSULOSIN HCL 0.4 MG CAPSULE	BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS
DUTASTERIDE 0.5 MG CAPSULE	BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS
PROVENTIL HFA 90 MCG INHALER	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING
ALBUTEROL SUL 2.5 MG/3 ML SOLN	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING
DULERA 200 MCG/5 MCG INHALER	BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED
DULERA 100 MCG/5 MCG INHALER	BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED
DULERA 200 MCG/5 MCG INHALER	BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED
DULERA 100 MCG/5 MCG INHALER	BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED
METOPROLOL TARTRATE 25 MG TAB	BETA-ADRENERGIC BLOCKING AGENTS
METOPROLOL TARTRATE 100 MG TAB	BETA-ADRENERGIC BLOCKING AGENTS
PROPRANOLOL 40 MG TABLET	BETA-ADRENERGIC BLOCKING AGENTS
ATENOLOL 25 MG TABLET	BETA-ADRENERGIC BLOCKING AGENTS
METOPROLOL TARTRATE 50 MG TAB	BETA-ADRENERGIC BLOCKING AGENTS
ATENOLOL 100 MG TABLET	BETA-ADRENERGIC BLOCKING AGENTS
METOPROLOL TARTRATE 25 MG TAB	BETA-ADRENERGIC BLOCKING AGENTS
ATENOLOL 50 MG TABLET	BETA-ADRENERGIC BLOCKING AGENTS
LITHIUM CARBONATE ER 300 MG TB	BIPOLAR DISORDER DRUGS
LITHIUM CARBONATE ER 450 MG TB	BIPOLAR DISORDER DRUGS
NIFEDIPINE ER 30 MG TABLET	CALCIUM CHANNEL BLOCKING AGENTS
NIFEDIPINE ER 60 MG TABLET	CALCIUM CHANNEL BLOCKING AGENTS
NIFEDIPINE ER 30 MG TABLET	CALCIUM CHANNEL BLOCKING AGENTS
DILTIAZEM 24H ER(XR) 240 MG CP	CALCIUM CHANNEL BLOCKING AGENTS

AMLODIPINE BESYLATE 10 MG TAB	CALCIUM CHANNEL BLOCKING AGENTS
NIFEDIPINE ER 90 MG TABLET	CALCIUM CHANNEL BLOCKING AGENTS
AMLODIPINE BESYLATE 5 MG TAB	CALCIUM CHANNEL BLOCKING AGENTS
AMLODIPINE BESYLATE 10 MG TAB	CALCIUM CHANNEL BLOCKING AGENTS
AMLODIPINE BESYLATE 10 MG TAB	CALCIUM CHANNEL BLOCKING AGENTS
AMLODIPINE BESYLATE 5 MG TAB	CALCIUM CHANNEL BLOCKING AGENTS
NIFEDIPINE ER 60 MG TABLET	CALCIUM CHANNEL BLOCKING AGENTS
CALCIUM 600 MG TABLET	CALCIUM REPLACEMENT
CEPHALEXIN 500 MG CAPSULE	CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION
ARICEPT 10 MG TABLET	CHOLINESTERASE INHIBITORS
XARELTO 20 MG TABLET	DIRECT FACTOR XA INHIBITORS
XARELTO 10 MG TABLET	DIRECT FACTOR XA INHIBITORS
XARELTO 15 MG TABLET	DIRECT FACTOR XA INHIBITORS
BD SHARPS COLLECTOR 1.5 QUART	DURABLE MEDICAL EQUIPMENT,MISCELLANEOUS
PAZEO 0.7% EYE DROPS	EYE ANTIHISTAMINES
DUREZOL 0.05% EYE DROPS	EYE ANTI-INFLAMMATORY AGENTS
ASMANEX TWISTHALER 220 MCG #60	GLUCOCORTICOIDS, ORALLY INHALED
ASMANEX TWISTHALR 220 MCG #120	GLUCOCORTICOIDS, ORALLY INHALED
ASMANEX TWISTHALER 110 MCG #30	GLUCOCORTICOIDS, ORALLY INHALED
FAMOTIDINE 20 MG TABLET	HISTAMINE H2-RECEPTOR INHIBITORS
ALLOPURINOL 300 MG TABLET	HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS
ALLOPURINOL 100 MG TABLET	HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS
ALLOPURINOL 300 MG TABLET	HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS
ALLOPURINOL 100 MG TABLET	HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS
HUMULIN N 100 UNIT/ML VIAL	INSULINS
HUMALOG 100 UNIT/ML VIAL	INSULINS
HUMALOG 100 UNITS/ML KWIKPEN	INSULINS
HUMULIN R 100 UNIT/ML VIAL	INSULINS
HUMULIN 70-30 VIAL	INSULINS
METOCLOPRAMIDE 10 MG TABLET	INTESTINAL MOTILITY STIMULANTS
MONTELUKAST SOD 10 MG TABLET	LEUKOTRIENE RECEPTOR ANTAGONISTS
CLINDAMYCIN HCL 150 MG CAPSULE	LINCOSAMIDE ANTIBIOTICS
EZETIMIBE 10 MG TABLET	LIPOTROPICS
FENOFIBRIC ACID DR 135 MG CAP	LIPOTROPICS
FENOFIBRATE 54 MG TABLET	LIPOTROPICS
ZETIA 10 MG TABLET	LIPOTROPICS
TORSEMIDE 20 MG TABLET	LOOP DIURETICS
FUROSEMIDE 80 MG TABLET	LOOP DIURETICS
FUROSEMIDE 20 MG TABLET	LOOP DIURETICS
FUROSEMIDE 40 MG TABLET	LOOP DIURETICS
AZITHROMYCIN 250 MG TABLET	MACROLIDE ANTIBIOTICS
AZITHROMYCIN 200 MG/5 ML SUSP	MACROLIDE ANTIBIOTICS
CLARITHROMYCIN 250 MG TABLET	MACROLIDE ANTIBIOTICS
CLARITHROMYCIN 500 MG TABLET	MACROLIDE ANTIBIOTICS
TRUSOPT 2% EYE DROPS	MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS
TRAVATAN Z 0.004% EYE DROP	MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS
SIMBRINZA 1%-0.2% EYE DROPS	MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS

AZOPT 1% EYE DROPS	MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS
AZOPT 1% EYE DROPS	MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS
TRAVATAN Z 0.004% EYE DROP	MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS
NASONEX 50 MCG NASAL SPRAY	NASAL ANTI-INFLAMMATORY STEROIDS
BUPROPION HCL SR 100 MG TABLET	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)
DICLOFENAC SOD DR 50 MG TAB	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS
DICLOFENAC POT 50 MG TABLET	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS
MOBIC 7.5 MG TABLET	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS
GENTAMICIN 0.3% EYE DROP	OPHTHALMIC ANTIBIOTICS
VIGAMOX 0.5% EYE DROPS	OPHTHALMIC ANTIBIOTICS
AMOX-CLAV 200-28.5 MG/5 ML SUS	PENICILLIN ANTIBIOTICS
AMOXICILLIN 500 MG CAPSULE	PENICILLIN ANTIBIOTICS
CLOPIDOGREL 75 MG TABLET	PLATELET AGGREGATION INHIBITORS
SPIRONOLACTONE 50 MG TABLET	POTASSIUM SPARING DIURETICS
SPIRONOLACTONE 100 MG TABLET	POTASSIUM SPARING DIURETICS
SPIRONOLACTONE 25 MG TABLET	POTASSIUM SPARING DIURETICS
SPIRONOLACTONE 25 MG TABLET	POTASSIUM SPARING DIURETICS
TRIAMTERENE-HCTZ 37.5-25 MG TB	POTASSIUM SPARING DIURETICS IN COMBINATION
PANTOPRAZOLE SOD DR 40 MG TAB	PROTON-PUMP INHIBITORS
ESOMEPRAZOLE MAG DR 40 MG CAP	PROTON-PUMP INHIBITORS
PANTOPRAZOLE SOD DR 40 MG TAB	PROTON-PUMP INHIBITORS
OMEPRAZOLE DR 20 MG CAPSULE	PROTON-PUMP INHIBITORS
ESOMEPRAZOLE MAG DR 20 MG CAP	PROTON-PUMP INHIBITORS
AVELOX 400 MG TABLET	QUINOLONE ANTIBIOTICS
CIPROFLOXACIN HCL 500 MG TAB	QUINOLONE ANTIBIOTICS
LEVOFLOXACIN 250 MG TABLET	QUINOLONE ANTIBIOTICS
PROZAC 20 MG PULVULE	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)
PROZAC 40 MG PULVULE	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)
ESCITALOPRAM 20 MG TABLET	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)
CITALOPRAM HBR 40 MG TABLET	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)
PAROXETINE HCL 40 MG TABLET	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)
FLUOXETINE HCL 10 MG TABLET	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)
CITALOPRAM HBR 20 MG TABLET	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)
SERTRALINE HCL 25 MG TABLET	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)
PAROXETINE HCL 20 MG TABLET	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)
SERTRALINE HCL 100 MG TABLET	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)
PROZAC 10 MG PULVULE	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)
CITALOPRAM HBR 10 MG TABLET	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)
FLUOXETINE HCL 20 MG TABLET	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)
CYMBALTA 60 MG CAPSULE	SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)
DULOXETINE HCL DR 20 MG CAP	SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)
CYMBALTA 20 MG CAPSULE	SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)
DULOXETINE HCL DR 30 MG CAP	SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)
VENLAFAXINE HCL 75 MG TABLET	SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)
CYMBALTA 30 MG CAPSULE	SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)
CYCLOBENZAPRINE 5 MG TABLET	SKELETAL MUSCLE RELAXANTS
CYCLOBENZAPRINE 10 MG TABLET	SKELETAL MUSCLE RELAXANTS

TIZANIDINE HCL 2 MG TABLET	SKELETAL MUSCLE RELAXANTS
TIZANIDINE HCL 4 MG TABLET	SKELETAL MUSCLE RELAXANTS
BACLOFEN 10 MG TABLET	SKELETAL MUSCLE RELAXANTS
CYCLOBENZAPRINE 10 MG TABLET	SKELETAL MUSCLE RELAXANTS
BACLOFEN 10 MG TABLET	SKELETAL MUSCLE RELAXANTS
TRINTELLIX 10 MG TABLET	SSRI, SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS
TRINTELLIX 20 MG TABLET	SSRI, SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS
SYMBYAX 12-25 MG CAPSULE	SSRI-ANTIPSYCH, ATYPICAL,DOPAMINE,SEROTONIN ANTAG
SYMBYAX 6-25 MG CAPSULE	SSRI-ANTIPSYCH, ATYPICAL,DOPAMINE,SEROTONIN ANTAG
DOXYCYCLINE HYCLATE 100 MG TAB	TETRACYCLINE ANTIBIOTICS
HYDROCHLOROTHIAZIDE 12.5 MG CP	THIAZIDE AND RELATED DIURETICS
HYDROCHLOROTHIAZIDE 12.5 MG CP	THIAZIDE AND RELATED DIURETICS
CHLORTHALIDONE 25 MG TABLET	THIAZIDE AND RELATED DIURETICS
HYDROCHLOROTHIAZIDE 12.5 MG CP	THIAZIDE AND RELATED DIURETICS
SYNTHROID 50 MCG TABLET	THYROID HORMONES
SYNTHROID 112 MCG TABLET	THYROID HORMONES
SYNTHROID 75 MCG TABLET	THYROID HORMONES
SYNTHROID 150 MCG TABLET	THYROID HORMONES
LEVOTHYROXINE 25 MCG TABLET	THYROID HORMONES
LEVOTHYROXINE 88 MCG TABLET	THYROID HORMONES
SYNTHROID 125 MCG TABLET	THYROID HORMONES
SYNTHROID 25 MCG TABLET	THYROID HORMONES
SYNTHROID 175 MCG TABLET	THYROID HORMONES
SYNTHROID 100 MCG TABLET	THYROID HORMONES
LEVOTHYROXINE 150 MCG TABLET	THYROID HORMONES
LEVOTHYROXINE 100 MCG TABLET	THYROID HORMONES
FLUOCINONIDE 0.05% OINTMENT	TOPICAL ANTI-INFLAMMATORY STEROIDAL
LIDOCAINE 5% PATCH	TOPICAL LOCAL ANESTHETICS
LIDODERM 5% PATCH	TOPICAL LOCAL ANESTHETICS
AMITRIPTYLINE HCL 100 MG TAB	TRICYCLIC ANTIDEPRESSANTS,REL.NON-SEL.REUPT-INHIB
AMITRIPTYLINE HCL 50 MG TAB	TRICYCLIC ANTIDEPRESSANTS,REL.NON-SEL.REUPT-INHIB
DOXEPIN 25 MG CAPSULE	TRICYCLIC ANTIDEPRESSANTS,REL.NON-SEL.REUPT-INHIB
DOXEPIN 10 MG CAPSULE	TRICYCLIC ANTIDEPRESSANTS,REL.NON-SEL.REUPT-INHIB
AMITRIPTYLINE HCL 25 MG TAB	TRICYCLIC ANTIDEPRESSANTS,REL.NON-SEL.REUPT-INHIB
AMITRIPTYLINE HCL 50 MG TAB	TRICYCLIC ANTIDEPRESSANTS,REL.NON-SEL.REUPT-INHIB
STRATTERA 60 MG CAPSULE	TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE
STRATTERA 100 MG CAPSULE	TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE
ELMIRON 100 MG CAPSULE	URINARY TRACT ANALGESIC AGENTS
OXYBUTYNIN CL ER 5 MG TABLET	URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT
OXYBUTYNIN CL ER 10 MG TABLET	URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT
ISOSORBIDE DINITRATE 10 MG TAB	VASODILATORS,CORONARY
CYANOCOBALAMIN 10,000 MCG/10	VITAMIN B12 PREPARATIONS