

Bring This to the Pharmacist

You can walk into a pharmacy with a bag of bottles and no idea what to ask. This is the ask.

DAY TO DAY DEMENTIA

There is a free medication review, and almost nobody uses it

Every Medicare Part D plan is **required by federal law** to run a Medication Therapy Management program — a structured review of everything the person takes, with a pharmacist or other qualified provider. If you qualify, **it costs nothing**. Most people have never heard of it.

It is not a dispensing check at the counter. You get a conversation about every drug and the reason it is being taken, plus three written documents: a summary of the review, a *Recommended To-Do List*, and a *Medication List* with room for your own notes.

WHO QUALIFIES

Plans set their own thresholds within federal rules, and it turns on three things at once: multiple chronic conditions, multiple Part D drugs, and expected annual drug costs at or above a set amount.

- **Alzheimer's disease is one of ten core conditions CMS requires every plan to include.** Since April 2024, no plan may leave it off its targeting list.
- A plan may require you to be taking as many as **eight** Part D drugs, but no more than eight. Many plans set the bar lower.
- The cost threshold is **\$1,276 for 2026** (it was \$1,623 for 2025). CMS sets it each year at the average annual cost of eight generic drugs.

Say this on the phone. Call the number on the back of the drug plan card: *"I want to know whether he qualifies for your Medication Therapy Management program, and how to schedule the comprehensive medication review."* If the answer is no, ask *why* not — the criteria are specific, and a wrong answer from a call center is worth a second call.

The four questions

Ask these about **every** drug on the list, one at a time. A pharmacist doing a structured review has more than fifteen minutes and is trained in exactly this.

1	What is this one treating? If nobody in the room can say, that is the finding.
2	What would we expect to happen if it came off? Ask for the specific expected consequence, not a general warning.
3	What is the smallest list that still makes sense for someone at this stage, with these goals?
4	What here interacts, duplicates, or works against something else?

Free to print, copy, and share. Please pass it on to anyone who needs it.

daytodaydementia.com

Practical, honest company for people caring for someone with dementia.

Every bottle, on one sheet

Bring the original containers too — the over-the-counter ones, the supplements, the ones from the other doctor, and the ones you suspect are not actually being taken.

DRUG & STRENGTH	HOW OFTEN	WHAT IT IS FOR	PRESCRIBED BY	STARTED	STILL NEEDED? — PHARMACIST'S NOTE

MATCH THE SYMPTOM TO THE DATE

A new symptom that began within weeks of a new drug is the most useful pattern you can hand a pharmacist.

NEW SYMPTOM — CONFUSION, FALLS, DROWSINESS, AGITATION, DRY MOUTH, CONSTIPATION	STARTED WHEN	ANYTHING ADDED OR CHANGED IN THE FOUR WEEKS BEFORE THAT

TWO THINGS TO NAME OUT LOUD

The Beers Criteria	The American Geriatrics Society's list of drugs that are potentially inappropriate in adults 65 and over; the current version is the 2023 update . Ask: <i>"Is anything here flagged in the Beers Criteria?"</i> Then ask about the AGS Alternatives List , added in late 2025, which names what to use instead.
Anticholinergic burden	Bladder drugs, older antihistamines, some antidepressants and some sleep aids each carry an anticholinergic load, and it adds up across the whole list. Ask: <i>"Can you total the anticholinergic burden across everything he takes?"</i> Almost nobody has ever added it up.

If something should come off: change *one* thing at a time, taper what needs tapering, write down two or three observable things first — sleep, appetite, steadiness on the feet — and agree a review date at the same time as the change, not afterward.