METIER PHARMACY CO.
Pharmacy *Unscripted*

Phone: 602-899-6960 **Fax:** 602-899-6961

4214 E Indian School Rd Ste 103
Phoenix, Arizona 85018
info@metierpharmacy.com
www.metierpharmacy.com

PATIENT INFORMATION

Deliver Here ☐

(Complete the following or include demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: ☐Male ☐Female
Email : _____
Primary Language: _____

PRESCRIBER INFORMATION

Deliver Here ☐

Name: _____
State License #: _____ NPI #: _____
DEA #: _____

Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

Metier Pharmacy can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Primary Diagnosis: _____ ICD-10 Code: _____ Date of Diagnosis: _____
**Please include Dx Code # and description Prior Failed Meds: _____
To expedite prior authorization services, please provide Chemo regimen/schedule, last clinical notes and/or lab values/scans:

PRESCRIPTION

Name	Strength	Directions		QUANTITY	REFILLS
☐ AFINITOR					
☐ GLEEVEC					
☐ MEKINIST/TAFLINAR					
☐ SPRYCEL					
☐ SUTENT					
☐ TARCEVA					
☐ TASIGNA					
☐ TEMODAR					
☐ VOTRIENT					
☐ XELODA					
☐ ZYTIGA					
☐ OTHER					
ANTIEMETICS ☐ Compazine					
☐ Emend Tri-fold		Take 1 capsule (125mg) by mouth on day 1, and take 1 capsule (80mg) by mouth on day 2 and day 3 of chemo cycle	Chemo cycle frequency: _____ days		
☐ Reglan					
☐ Sancuso Patch					
☐ Other					

PHYSICIAN SIGNATURE

To Physician: By signing this form and utilizing our services, you are also authorizing Metier Pharmacy to serve as your prior authorization agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Physician Signature: **Date:**