



Phone: 602-899-6960

Fax: 602-899-6961

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

Please print clearly.

Patient Information

Patient: _____ male female DOB: _____
First Name Last Name

Address: _____
Street City State Zip

Primary phone number: _____ Cell Alternate phone number: _____ Cell
 Email address: _____ SS#: _____

Patient Information (continued)

What is the patient's medical condition/diagnosis relative to this application?

What drug/treatment is the patient being prescribed?

Funding Criteria Qualification

Number of people in patient's household (including patient): _____

What is patient's approximate annual gross household income? _____

Is patient a legal U.S. resident? yes no Does patient have insurance coverage? yes no

Insurance Information

Primary insurance: _____ Primary health insurance phone #: _____
 Primary health insurance ID #: _____ Primary health insurance group #: _____

Prescription insurance: _____ Prescription insurance phone #: _____
(if different from above)

Prescription insurance ID #: _____ Prescription insurance group #: _____

Provider Information

Provider's name: _____ Contact Person: _____
First Name Last Name First Name Last Name

Office address: _____
Street City State Zip

Phone #: _____ Fax #: _____ NPI #: _____ DEA #: _____

If you are requesting on someone's behalf, please complete the section below.

Requester Information

Requester's name: _____
First Name Last Name

Address: _____
Street City State Zip

Primary phone number: _____ cell Alternate phone number: _____ cell
 Email address: _____ Relationship to patient: _____

Authorization

Requester signature: _____ Date: _____

Please print patient name: _____
First Name Last Name

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