METIER PHARMACY CO.
Pharmacy Unscripted

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PATIENT INFORMATION

Patient Name: ______________________

Address: ______________________

City, State, Zip: ______________________

Primary Phone: __________ DOB: __________

Alternate Phone: __________ Gender: ☐ Male ☐ Female

Email : ______________________

Primary Language: __________

PRESCRIBER INFORMATION

Name: ______________________

State License #: __________ NPI # __________

DEA #: ______________________

Address: ______________________

City, State Zip: ______________________

Phone: __________ Fax __________

Contact Person: __________ Phone: __________

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

INSURANCE INFORMATION

If available, please fax copy of prescription insurance cards with this form(front and back).

Diagnosis: Primary ICD-10 __________ Other ICD-10 __________

Medication	Strength	Directions	Quantity	Refills
COMBINATION ANTIRETROVIRALS				
☐ ATRIPLA	300/200/600mg			
☐ COMBIVIR	300/150mg			
☐ COMPLERA	300/200/50mg			
☐ EPZICOM	600/300mg			
☐ STRIBILD	150/150/200/300mg			
☐ TRIZIVIR	300/150/300mg			
☐ TRUVADA	300/200mg			
☐ TRIUMEQ	50/600/300mg			
NNRTIs				
☐ EDURANT	25mg			
☐ INETELENCE				
☐ RESCRIPTOR				
☐ SUSTIVA				
☐ VIRAMUNE				
☐ VIRAMUNE XR	400mg			
NRTIs				
☐ EMTRIVA				
☐ EPIVIR				
☐ RETROVIR				
☐ VIDEX				
☐ VIREAD				
☐ ZERIT				
☐ ZIAGEN				

Medication	Strength	Directions	Quantity	Refills
PROTEASE INHIBITORS				
☐ APTIVUS				
☐ CRIXIVAN				
☐ INVIRASE				
☐ KALETRA				
☐ LEXIVA				
☐ NORVIR Tabs	100mg			
☐ NORVIR Caps	100mg			
☐ PREZISTA				
☐ REYATAZ				
☐ VIRACEPT				
INTEGRASE INHIBITORS				
☐ ISENTRESS				
☐ TIVICAY				
ENTRY/FUSION INHIBITORS				
☐ FUZEON	90mgVial			
☐ SELZENTRY				
GROWTH HORMONES				
☐ SEROSTIM				
☐ EGRIFTA				
OTHER MEDICATIONS				
☐ AZITHROMYCIN				
☐ BACTRIM				
☐ FLUCONAZOLE				

Today's Date__________ Date Needed:__________

Ship to: ☐ Patient ☐ Physician Other:______________________

To Prescriber: 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 copay assistance foundations.

Signature: **Date:**

CONFIDENTIALITY NOTICE

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