

Creighton University 2008 Prescription Hardship Application Form

Complete the top half of this form and fax to the CUMC Clinic Pharmacy @ 449-4531

Employee Name: _____ Patient Name: _____

Employee ID #: _____ Patient DOB: _____

Date: _____ Contact Phone #: _____

Drug: _____ (one drug per application)

I authorize CUMC Clinic Pharmacy to contact CU Human Resources to confirm that my current annual CU salary meets the hardship requirement. If approved, I understand the Hardship benefit (\$25 per a 30 day supply) is valid only through December 31, 2008, and the prescription must be filled at the CUMC Clinic Pharmacy.

Employee Signature: _____

CUMC Clinic Pharmacy Use Only:

Is this a brand name drug with no generic equivalent?

Yes No

Is the expected duration of therapy 4 months or more?

Yes No

Is the WHI contracted price of a 30 day supply \$150.00 or more?

Yes No

Is the employee's annual CU income less than \$50,000?

Yes No

Is the employee enrolled in a PPO I or II plan (not CCAP)?

Yes No

Comments: _____

Pharmacist Signature: _____

Date: _____ Time: _____

Place Pharmacy Procedure
Sticker here.