CREORX

Prior Authorization Request Form
Benefit Limit Override

Please Note: All information below is required to process this request.

Patient Information (required)			Pharmacy Information (required)		
Patient Name:			Pharmacy Name:		
Insurance ID#:			NPI#:	Store number:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone 1:	Phone 2:		City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:	Directions for Use:	Quantity	Date of Last Fill	Name of Physician

☐ Attorney/Case Manager: _____ ☐ Approved ☐ Denied Date: _____

INTERNAL USE ONLY

☐ Denied ☐ Approved Approved Through: _____ Authorized By: _____

SIGN HERE

Signature: _____ Authorized Date: _____

This request may be denied unless all required information is received.

Please fax the form to (878) 900-6052

Submit form by email

For real-time submission, visit creorx.com and click Provider, Prior Authorization Form.