



Prior Authorization Request Form
Benefit Limit Override

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

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

Medication Information (required) table with columns: Medication Name, Strength, Dosage Form, Directions for Use, Quantity, Date of Last Fill, Name of Physician. Multiple empty rows for data entry.

Attorney/Case Manager: \_\_\_\_\_ Approved Denied Date: \_\_\_\_\_

INTERNAL USE ONLY

Denied Approved Approved Through: \_\_\_\_\_ Authorized By: \_\_\_\_\_

Signature: \_\_\_\_\_ Authorized Date: \_\_\_\_\_

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

Please fax the form to (878) 900-6052

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

This document and others, if attached, contain information that is privileged, confidential, and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of CreoRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing, or using the information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.