

# Creighton University 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 the end of the calendar year, and the prescription must be filled at the CUMC Clinic Pharmacy.

Employee Signature: \_\_\_\_\_

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### 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.~~