pennsylvania
DEPARTMENT OF HEALTH

CHRONIC RENAL DISEASE PROGRAM
REQUEST FOR MEDICAL EXCEPTION FOSRENOL®

Please note: This form must be included with the medical exception request.

Patient's Name:	
CRDP ID Number:	
Name of Product for which Exception Requested:	**Fosrenol® --** please submit current CaPO4 lab values and if this is new therapy, please submit date therapy was initiated and CaPO4 lab values prior to therapy being initiated.
Treatment Modality:	☐ **Hemodialysis** ☐ **Peritoneal Dialysis** ☐ **Transplant**
Diagnosis:	

LIST CRDP FORMULARY PRODUCTS USED PREVIOUSLY TO TREAT THE CONDITION FOR WHICH YOU ARE REQUESTING AN EXCEPTION

Name of Product(s)	Duration of Therapy	Outcome – Describe failure of therapy

Prescribing Physician:	
License Number:	
Telephone Number:	**( ) -** **Area Code**
Signature of Facility Dietitian	**Please indicated that the patient has been educated about dietary restrictions to control phosphate levels:** ☐ **Yes** ☐ **No** **Signature:** **Date:**
Facility Name:	
Facility Address:	
Telephone Number:	**( ) -** **Area Code**
	☐ **Check box if you would like to receive a status update of request via email. If box checked, please provide email address and facility ID and NPI.**
Facility ID and NPI Number(s):	
Email Address:	
Physician Signature:	Date:

If you have any questions, please do not hesitate to contact the Chronic Renal Disease Program Drug Utilization Review Unit at 1-800-835-4080 or **FAX this form and attachments to 1-888-656-5076.**

RETURN THIS FORM AND ATTACHMENTS TO:

Chronic Renal Disease Program
Drug Utilization Review
P.O. Box 8811
Harrisburg, PA 17105-8811
or FAX to 1-888-656-5076

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