



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:	<input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Signature: _____ Date: _____	
Facility Name:		
Facility Address:		
Telephone Number:	() - Area Code	
	<input type="checkbox"/> 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