



## CHRONIC RENAL DISEASE PROGRAM REQUEST FOR MEDICAL EXCEPTION

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

<b>Patient's Name:</b>		
<b>CRDP ID Number:</b>		
<b>Name of Product for which Exception Requested:</b>		
<b>Treatment Modality:</b>	<input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Transplant	
<b>Diagnosis:</b>		
<b>LIST CRDP FORMULARY PRODUCTS USED PREVIOUSLY TO TREAT THE CONDITION FOR WHICH YOU ARE REQUESTING AN EXCEPTION</b>		
<b>Name of Product(s)</b>	<b>Duration of Therapy</b>	<b>Outcome – Describe failure of therapy</b>
<b>Prescribing Physician:</b>		
<b>License Number:</b>		
<b>Telephone Number:</b>	(      ) - Area Code	
<b>Facility Name:</b>		
<b>Facility Address:</b>		
<b>Telephone Number</b>	(      ) - Area Code	
	<input type="checkbox"/> <b>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.</b>	
<b>Facility ID and NPI Number(s):</b>		
<b>Email Address:</b>		
<b>Physician Signature:</b>	<b>Date:</b>	

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