



CHRONIC RENAL DISEASE PROGRAM REQUEST FOR MEDICAL EXCEPTION NUTRITIONAL SUPPLEMENTS

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:	<input type="checkbox"/> Boost® Diabetic —2 (240mL or 237mL) cans per day maximum <input type="checkbox"/> Boost® High Protein —2 (240mL or 237mL) cans per day maximum <input type="checkbox"/> Liquacel® —2 (960mL) bottles per month <input type="checkbox"/> Megace® ES —625mg (5mL) per day maximum <input type="checkbox"/> Nepro® —2 (240mL) cans per day maximum <input type="checkbox"/> ProSource® Liquid —2 (960mL) bottles per month <input type="checkbox"/> ProSource® Liquid No Carb —2 (960mL) bottles per month <input type="checkbox"/> ProSource® Protein Powder —3 (270gm) cans per month <input type="checkbox"/> Proteinex® Liquid —2 (900mL) bottles per month Please submit the most current albumin lab values (x 2) with request. A copy of the Medical Assistance (MA) denial will be needed for cardholders who are enrolled in MA.
Treatment Modality:	<input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Transplant
Prescribing Physician:	
License Number:	
Telephone Number:	() - Area Code
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