



**CHRONIC RENAL DISEASE PROGRAM  
REQUEST FOR MEDICAL EXCEPTION REVELA®**  
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>Renvela®</b> --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.	
<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</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>Signature of Facility Dietitian:</b>	Please indicated that the patient has been educated about dietary restrictions to control phosphate levels: <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Signature:</b> _____ <b>Date:</b> _____	
<b>Facility Name:</b>		
<b>Facility Address:</b>		
<b>Telephone Number:</b>	(     ) - 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.	
<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