



CHRONIC RENAL DISEASE PROGRAM REQUEST FOR MEDICAL EXCEPTION

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:		
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	
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
or **FAX to 1-888-656-5076**