pennsylvania
DEPARTMENT OF HEALTH

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:	☐ **Boost® Diabetic**—2 (240mL or 237mL) cans per day maximum ☐ **Boost® High Protein**—2 (240mL or 237mL) cans per day maximum ☐ **Liquacel®**—2 (960mL) bottles per month ☐ **Nepro®**—2 (240mL) cans per day maximum **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:	☐ **Hemodialysis** ☐ **Peritoneal Dialysis** ☐ **Transplant**
Prescribing Physician:	
License Number:	
Telephone Number:	**( ) -** **Area Code**
Facility Name:	
Facility Address:	
Telephone Number:	**( ) -** **Area Code**
	☐ **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**