pennsylvania
DEPARTMENT OF HEALTH

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:	☐ **Hemodialysis** ☐ **Peritoneal Dialysis** ☐ **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**		
	☐ **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**