pennsylvania
DEPARTMENT OF HEALTH

CHRONIC RENAL DISEASE PROGRAM
REQUEST FOR MEDICAL EXCEPTION Velphoro®

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:	**Velphoro®** - **(3 tabs/daily maximum) -** please submit date therapy was initiated, current CaPO4 lab values, and if ongoing therapy, please also include labs prior to initiating therapy.
Treatment Modality:	☐ **Hemodialysis** ☐ **Peritoneal Dialysis** ☐ **Transplant**

• Documented usage/clinical failure with Renvela 9 tabs per day required or Fosrenol 3000mg per day.

• Must have proof of other insurance coverage, such as Medicare Part D or another insurer.

• If the other insurance requires a prior authorization, it must be approved, prior to CRDP providing reimbursement for any claim.

• CRDP must be secondary payor on any associated claim for this agent.

• In the event of non-compliance, CRDP will not continue reimbursement.

Prescribing Physician:	
Physician NPI Number:	
Telephone Number:	**( ) -** **Area Code**
Signature of Facility Dietitian:	**Please indicated that the patient has been educated about dietary restrictions to control phosphate levels: ☐ Yes ☐ No** **Signature:** **Date:**
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**

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