TEXAS Health and Human Services

**Form 1338**
November 2022-E

Texas Vendor Drug Program

# Cystic Fibrosis Agents (Kalydeco/Orkambi/Symdeko) - Medicaid Standard PA Addendum

Please complete the information below. The information is essential to processing the prior authorization for the selected drug. Please fax the Texas Standard Prior Authorization Request Form for Prescription Drug Benefits (TDI Form NOFR002) and **Form 1338** to the Texas Prior Authorization Call Center at 866-469-8590. Incomplete forms or failure to submit both forms may cause delays in patient care, prior authorization denial, or both. This form is only for people enrolled in Medicaid fee-for-service. If the patient is enrolled in managed care, contact the MCO for forms and instructions.

## Section I – Patient Information

| Patient Name (First, Last, Middle) | Medicaid ID | Date of Birth |
|---|---|---|
| | | |

## Section II – Prescriber Information

| Prescriber Name | NPI | Phone No. with Area Code |
|---|---|---|
| | | |

## Section III – Medication Information

Does the patient have a gene mutation of 2789+5G-+A, 3272-26A-+G, 3849+10kbC-+T, 711+3A-+G, E831X, A1067T, A455E, D110E, D110H, D1152H, D1270N, D579G, E193K, E56K, F1052V, F1074L, G1069R, G1244E, G1349D, G178R, G551D, G551S, K1060T, L206W, P67L, R1070Q, R1070W, R117C, R117H, R347H, R352Q, R74W, S1251N, S1255P, S549N, S549R, S945L or S977F?

◯ Yes, identify gene mutation(s): _____

◯ No

1. Does the patient have a gene mutation of F508del?

◯ Yes

◯ No

## Section IV – Review

By signing and dating below (check the appropriate box):

☐ **Expedited or Urgent Review Requested:** I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of Prescriber or Prescriber's Designee _____ Date _____