BlueCross BlueShield
Federal Employee Program

ENFLONSIA
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Enflonsia

(clesrovimab-cfor)

***Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Is Enflonsia being used to prevent infection caused by RSV (Respiratory Syncytial Virus)? ❑Yes ❑No

2. What is the patient's age at the start of RSV season? _____ months

3. **May-September Month Range**: Will the first dose be administered one month prior to or during the RSV season (RSV season starts November 1st each year. The first dosage could be administered as early as October 1st)? ❑Yes ❑No