



**BlueCross  
BlueShield**

Federal Employee Program

## COVID-19 ORAL ANTIVIRALS

### 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: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R <input type="text"/>			Physician Signature:		
<b>PHYSICIAN COMPLETES</b>						

## COVID-19 Oral Antiviral Agents

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

Please select medication and provide quantity:

<input type="checkbox"/> Molnupiravir	qty _____ per 30 days	<input type="checkbox"/> Paxlovid 150mg (nirmatrelvir/ritonavir)	qty _____ per 30 days
		<input type="checkbox"/> Paxlovid 300mg (nirmatrelvir/ritonavir)	qty _____ per 30 days

\*Check [www.fepblue.org/formulary](http://www.fepblue.org/formulary) to confirm which medication is part of the patient's benefit

1. Is this medication being prescribed for COVID-19 or another diagnosis? *Please select answer below:*

☐ COVID-19

☐ Other diagnosis (*please specify*): \_\_\_\_\_

2. Is the patient at high risk for progression to severe COVID-19? ☐ Yes ☐ No

3. Is the patient's diagnosis confirmed by direct SARS-CoV-2 viral testing? ☐ Yes ☐ No