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: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

COVID-19 Oral Antiviral Agents

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

Please select medication and provide quantity:

❑Molnupiravir qty _____ per 30 days

❑Paxlovid 150mg (nirmatrelvir/ritonavir) qty _____ per 30 days

❑Paxlovid 300mg (nirmatrelvir/ritonavir) qty _____ per 30 days

***Check 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