OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Cyproheptadine Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Allergic conjunctivitis
- ❑ Allergic rhinitis (perennial or seasonal)
- ❑ Angioedema
- ❑ Anaphylaxis (adjunct to epinephrine)
- ❑ Dermatographism
- ❑ Immune hypersensitivity reaction to blood or plasma
- ❑ Migraine prophylaxis
- ❑ Urticaria
- ❑ Vasomotor rhinitis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

The approval criteria is based on the guidance provided by the Centers for Medicare & Medicaid Services (CMS), the Pharmacy Quality Alliance, the American Geriatric Society and the National Committee for Quality Assurance (NCQA). "Use of High Risk Medications in the Elderly" is measure 238 of the Centers for Medicare & Medicaid Services Physician Quality Reporting System.

Risk acknowledgment:

Does the provider acknowledge that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population? ❑ **Yes** ❑ **No**

Does the provider wish to proceed with the originally prescribed medication? ❑ **Yes** ❑ **No**

Coverage of the drug is approvable after demonstrated failure to the alternatives below or we receive information as to why they would be inappropriate.

Select the medications the patient has a failure, contraindication, or intolerance to:

- ❑ Astepro
- ❑ Azelastine nasal spray
- ❑ Beconase AQ
- ❑ Cetirizine syrup
- ❑ Clarinex
- ❑ Clarinex-D 12-hour
- ❑ Clemastine
- ❑ Cyproheptadine tablet
- ❑ Desloratadine
- ❑ Desloratadine orally disintegrating tablet (ODT)
- ❑ Flunisolide nasal spray
- ❑ Fluticasone nasal spray
- ❑ Levocetirizine
- ❑ Mometasone nasal spray
- ❑ Nasonex
- ❑ Olopatadine nasal spray
- ❑ Omnaris
- ❑ Patanase
- ❑ Phenadoz
- ❑ Promethazine
- ❑ Promethegan
- ❑ Qnasl
- ❑ Qnasl Children's
- ❑ Semprex-D
- ❑ Timolol
- ❑ Topiramate
- ❑ Triamcinolone nasal spray
- ❑ Xhance
- ❑ Zafirlukast
- ❑ Zetonna

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.