Luminopia Enhanced Enrollment Form

To prescribe Luminopia fax this enrollment form to **833-596-2174** or use your **EHR** and send the following information in an eRx to **CoAssist Pharmacy**

Luminopia®

Patient Information

Patient Full Name: _____ DOB (MM/DD/YYYY): _____

Parent/Guardian Full Name: _____ Patient Gender: _____

Mobile Phone Number: _____ Email: _____

Street: _____ City: _____ State: _____ ZIP Code: _____

Insurance Information

Primary Insurance: _____ RX BIN: _____

Group #: _____ RX PCN: _____

Member ID: _____ RX GRP: _____

Diagnosis and Medical Information

ICD-10 Code Amblyopic Eye	Unspecified amblyopia	Deprivation amblyopia	Refractive amblyopia	Strabismic amblyopia	Amblyopia suspect
Right Eye:	☐ H53.001	☐ H53.011	☐ H53.021	☐ H53.031	☐ H53.041
Left Eye:	☐ H53.002	☐ H53.012	☐ H53.022	☐ H53.032	☐ H53.042

Previous Treatments for Amblyopia: ☐ Patching ☐ Atropine ☐ Other: _____ ☐ None

Duration of Prior Treatment: ☐ <3 Months ☐ 3-6 Months ☐ >6 Months

Additional Clinical Background:

Amblyopic Eye BCVA (Snellen) _____ Alignment (for Strabs Only) _____ Prism Diopters

Prescription Information

Product: Luminopia **NDC:** 60007088710

Directions: Use 1hr/day, 6 days/wk **Dispense quantity:** 1 unit

Number of Authorized Refills*: _____ Months (Refills)

(6+ refills are recommended) *Patient will be asked before each refill is processed

Prescribing Physician Information

Prescribing Physician Name: _____ NPI: _____

Group Practice/Site Name: _____ Phone: _____

Site Contact Name: _____ Fax: _____

Site Contact Email: _____

Street: _____ City: _____ State: _____ ZIP Code: _____

Prescriber Authorization:

I authorize this pharmacy and its representatives to act as my authorized agent to secure insurance coverage information and to initiate the insurer's prior authorization process for my patient. I also authorize this pharmacy and its representatives to sign any necessary forms on my behalf, including receipt and submission of any required prior authorization forms, appeal forms, letters of medical necessity, patient lab values and other patient data. If this pharmacy determines it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related product-specific coverage materials to another pharmacy of the patient's choice or within the patient's insurer's network. The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person named above. If you are not the intended recipient, you are hereby notified that any review, dissemination or duplication of this communication is strictly prohibited. Additionally, please contact the sender and destroy all copies of the original document.

Prescriber Signature Date (MM/DD/YYYY)