Luminopia Clinical Review Form

Fax with the Enrollment Form and chart notes to **(844) 444-0767.** **PRO-spectus** uses this form to request prior authorization from the patient's health plan.

Luminopia®
BEYOND THE PATCH

Why complete this form? It captures the clinical details health plans typically require for prior authorization in one place, so your office gets fewer follow-up calls and faxes asking for documentation, and your patient can start treatment sooner.

Patient Information

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

Diagnosis

Amblyopia Type: ☐ Anisometropic (refractive) ☐ Strabismic, small angle (≤10 PD) ☐ Mixed-mechanism

Amblyopic eye: ☐ Right ☐ Left ☐ Both

Clinical Background

Previous treatments for amblyopia: ☐ Patching ☐ Atropine ☐ Other: _____ ☐ None

Total months of prior treatment: _____

BCVA (Snellen) Right Eye: _____ Left Eye: _____

Medical Necessity Criteria

The patient meets the following criteria (check one per line)	Agree	Disagree	N/A
Previously tried patching or atropine for more than 6 months	☐	☐	
No documented condition preventing a continuous 60 minutes of near-screen treatment per day (e.g., parent reports the child cannot or will not watch TV/movies for more than 60 minutes daily)	☐	☐	
If myopia is present, it is not greater than -6.00 D spherical equivalent in either eye	☐	☐	☐
No history of light-induced seizures	☐	☐	

If you mark "Disagree" to any of the above, provide additional clinical context:

_____

_____

_____

Prescriber Attestation

Prescribing Physician Name: _____ NPI: _____

I attest that the information above is accurate and supported by the patient's medical record, and that Luminopia is medically necessary for this patient.

_____ _____

Prescriber Signature Date (MM/DD/YYYY)

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