Luminopia Enrollment Form

To prescribe Luminopia fax this enrollment form to **888-975-0603** or use your **EHR** and send the following information in an eRx to **PhilRx** pharmacy

Prescribing Physician Information

Prescribing Physician Name: _____ NPI: _____

Group Practice/Site Name: _____ Phone: _____

Site Contact Name: _____ Fax: _____

Address: Street: _____

City: _____ State: _____ Zip Code: _____

Patient Information

Patient Full Name: _____ D.O.B: _____
MM/DD/YYYY

Parent/Guardian Full Name: _____

Mobile Phone Number: _____ Email: _____

Prescription 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

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

Previous Treatments: ☐ Glasses ☐ Patching ☐ Atropine ☐ Other: _____
(If applicable)

Prescriber Signature **Date (MM/DD/YYYY)**