

LUMINOPIA

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:

- Amblyopia associated with anisometropia and/or with mild strabismus
- Other (ICD code, plus description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

- Is the patient currently being treated with the requested agent? Yes No
- Does the patient have an interpupillary distance of at least 52 mm? Yes No
- Will the patient use the requested digital therapy in combination with full-time refractive correction (e.g., glasses)? Yes No
- Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
If no, please provide support for using the requested agent for the patient's age for the requested indication: _____

For renewal requests:

- Has the patient had clinical benefit with the requested digital therapeutic? Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone:
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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