ASCENT | SINUVA® (mometasone furoate) sinus implant

☐ **Check if benefit investigation only**

Phone: 1-833-4-SINUVA (1-833-474-6882)
Monday – Friday, 8 AM – 8 PM ET

PATIENT ENROLLMENT FORM for SINUVA® (mometasone furoate)

Fax completed form to 1-844-745-2358

PATIENT INFORMATION

Name: | DOB (mm/dd/yyyy): | Gender: ☐ Male ☐ Female

Address: | City: | State: | Zip Code:

Home Phone: | Mobile Phone: | Email:

Is Patient a Resident of the United States: ☐ Yes ☐ No | What is Patient's Primary Language?

CLINICAL INFORMATION

Patient Diagnosis(es)/ICD-10-CM: ☐ **J33.0** Polyp of nasal cavity ☐ **J33.1** Polypoid sinus degeneration ☐ **J33.8** Other polyp of sinus ☐ **J33.9** Nasal polyp, unspecified ☐ Other:

Does Patient Currently Have Nasal Polyps: ☐ Yes ☐ No | Date of Last Ethmoid Sinus Surgery:

Total number of prior sinus surgeries: | Date of Last Course of Oral Corticosteroids:

Additional Medical Therapies Attempted for this diagnosis in the Past 6 Months:
☐ Antibiotics ☐ Compounded Rinses ☐ Nasal Sprays ☐ Inhalers ☐ Other:

Additional Medications Taken?

Does Patient Have Co-Morbid Conditions? ☐ Yes ☐ No *(Please check all that apply)*
☐ Asthma ☐ Allergies ☐ Mood Disorders ☐ Glaucoma ☐ Diabetes ☐ Bone Disease

Known Allergies: | Other Conditions:

**In lieu of filling out the insurance section, you may attach a copy (front & back) of the patient's insurance and prescription cards

PRIMARY INSURANCE

Primary Insurance: | Phone: | Relationship:

Last 4 digits of insured SSN: | DOB: | Employer:

Group #: | Policy #: | Member #:

Prescription/drug card company: | Phone:

Rx BIN #: | Group #: | Policy ID:

SECONDARY INSURANCE

Secondary Insurance: | Phone: | Relationship:

Last 4 digits of insured SSN: | DOB: | Employer:

Group #: | Policy #: | Member #:

Prescription/drug card company: | Phone:

Rx BIN #: | Group #: | Policy ID:

PRESCRIPTION

☐ **UNILATERAL** SINUVA (mometasone furoate) 1350 mcg Qty 1
[To be administered by physician. Route: Intrasinal]

☐ **BILATERAL** SINUVA (mometasone furoate) 1350 mcg Qty 2
[To be administered by physician. Route: Intrasinal]

PRESCRIBER INFORMATION

Prescriber Name: | Prescriber Tax ID #:

DEA #: | State License #:

NPI #: | PTAN #:

Prescriber Phone: | Practice/Facility Name:

Practice Street Address: | City: | State: | Zip:

Office Contact Name: | Office Contact Email:

Office Contact Phone: | Fax: | Preferred Method of Contact:

PRESCRIBER SIGNATURE

Prescriber Signature: | Date of Signature (mm/dd/yyyy):

By my signature above, I certify that the therapy prescribed is medically necessary and verify that the information provided is complete and accurate to the best of my knowledge. I also acknowledge that I have obtained a signed HIPAA authorization from the patient to release their health information and such other information as may be required to the Pharmacy, TrialCard and its affiliates and Intersect ENT to assist in obtaining coverage for the product and to assist in initiating therapy. I affirm that the patient consents to this release of information and has been informed and agrees that the information to be disclosed hereunder, once shared with others, will not be protected by state and federal privacy laws, provided that it is used and disclosed solely for the purposes stated herein. I authorize TrialCard and its affiliates, and the dispensing pharmacy to share information about this patient on my behalf, to convey this prescription to the pharmacy for dispensing and for the pharmacy to dispense per its customary and usual procedures.