SINUVA®
(mometasone furoate) sinus implant

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

PATIENT ENROLLMENT FORM for SINUVA

○ **New Patient**

Fax completed form to 1-844-745-2358

PATIENT INFORMATION

First Name: Last Name: Middle Initial:

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

Address: City: State: Zip Code:

Home Phone: Mobile Phone: Email:

PRIMARY MEDICAL INSURANCE

Primary Insurance: Subscriber Name: Relationship: DOB:

Group #: Policy #: Member #: Phone:

SECONDARY MEDICAL INSURANCE

Secondary Insurance: Subscriber Name: Relationship: DOB:

Group #: Policy #: Member #: Phone:

PRIMARY PRESCRIPTION INSURANCE

Prescription/drug card company: Phone:

Policy ID: Group #: Rx BIN #: PCN #:

PRESCRIPTION INFORMATION

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

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:

Tried and failed sinus therapies: ☐ Topical Nasal Corticosteroids ☐ Budenoside Nasal Rinse ☐ Other Nasal Rinses
☐ Antibiotics ☐ Nasal Decongestants ☐ Other

Known Allergies: Other Conditions:

☐ **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]

Please fax clinical notes with the SINUVA Enrollment Form to Connect at 1-844-745-2358 to expedite the approval process.

SERVICES REQUESTED (select one)

☐ Benefit Verification Only

☐ Benefit Verification + Prior Authorization Assistance (Buy & Bill)

☐ Benefit Verification + Prior Authorization Assistance + Specialty Pharmacy Triage

PRESCRIBER INFORMATION

First Name: Last Name: Middle Initial: Designation:

Prescriber Tax ID #: State License #:

NPI #: PTAN #:

Prescriber Phone: Practice/Facility Name:

Practice Street Address: City: Zip:

Office Contact Name: Office Contact Email:

Office Contact Phone: Fax: Preferred Method of Contact:

Site of Care (select one): ☐ Physician Office ☐ Hospital/Clinic Outpatient ☐ Surgical Center

PRESCRIBER SIGNATURE

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

By signing 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 attest that I have obtained all appropriate patient authorizations and consents, including a signed HIPAA authorization, to disclose the patient's protected health information, and such other information as may be required, to the Pharmacy, Intersect ENT and its agents, to use and disclose as may be necessary to assist in obtaining coverage for the product, initiating therapy, providing treatment support services, and administering the SINUVA program. I affirm that the patient has been informed and agrees that (1) information disclosed pursuant to the patient's authorization may no longer be protected by federal and state privacy laws and may be redisclosed, (2) pharmacy providers may receive remuneration from Intersect ENT in exchange for health information and/or support services provided to them, and (3) authorization is voluntary and refusal to consent will not affect the patient's ability to obtain treatment or insurance benefits. I authorize Intersect ENT and its agents, and the dispensing pharmacy, to share information about the 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.

Connect

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PATIENT CONSENT

By signing this form, I authorize my physician, pharmacies, and other healthcare providers ("Healthcare Providers") and my health insurers to share my health information with Intersect ENT, Inc. and its agents, including, but not limited to, reimbursement hub vendors, pharmacies, and data aggregators (collectively, "Intersect ENT"). I understand that my health information includes information relating to my medical condition, treatment, and insurance coverage, as well as identifying information about me (including, for example, my name, address, and date of birth). My health information will be shared with Intersect ENT so that Intersect ENT may provide me with various support and information to help me access SINUVA, which may include the following:

(1) contacting me to provide certain services to me, including reimbursement and coverage support, patient assistance and access programs
(2) contacting me to provide me with support services and information associated with SINUVA
(3) serve internal business purposes, such as marketing research, internal financial reporting and operational purposes, and
(4) carry out Intersect ENT's respective legal responsibilities.

I authorize Intersect ENT and companies working with Intersect ENT, to contact me to provide such services and information by mail, e-mail, fax, telephone call, text message (including calls and text messages with an automatic telephone dialing system or a prerecorded voice), and other mutually agreed means.

I understand that signing this authorization is voluntary and that my healthcare providers will not condition my treatment on my agreement to sign this authorization, and my health insurer will not condition payment for my treatment, insurance enrollment or eligibility for insurance benefits on my agreement to sign this authorization. I understand that I am entitled to receive a copy of this authorization after I sign it.

Once my health information has been disclosed to Intersect ENT, I understand that it may be redisclosed by them and no longer protected by federal and state privacy laws. However, Intersect ENT agrees to protect my health information by using and disclosing it only for the purposes detailed in this authorization or as permitted or required by law. I understand that pharmacies may receive remuneration from Intersect ENT in exchange for my health information or other support services.

This authorization will remain in effect until I revoke my authorization. I may revoke this authorization at any time by mailing a letter to the Connect Patient Services Program, 6000 Park Lane, Pittsburgh PA 15275. Revoking this authorization will end further disclosure of my health information to Intersect ENT by my healthcare providers and health insurers when they receive a copy of the revocation, but it will not apply to information they have already disclosed to Intersect ENT based on this authorization.

Print name of patient/legal representative: _____

Signature: _____

Date: _____

Connect