SINUVA® (mometasone furoate) sinus implant

Please complete all fields with black ink and fax form to **1- 844-745-2358.**
For help, please call **1-833-4-SINUVA (1-833-474-6882)**

ASCENT Reimbursement Support

Patient Enrollment Form

New ASCENT Patient   **Existing** ASCENT Patient

PROCUREMENT METHOD

- ☐ Buy & Bill
- ☐ Specialty Pharmacy

CHECK SERVICES REQUESTED

- ☐ Benefits Investigation
- ☐ Prior Authorization
- ☐ Appeals Assistance

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

PRESCRIBER INFORMATION

Prescriber Name: ______________________________

Prescriber Tax ID #: ______________ DEA #: ______________

State License #: ______________ NPI #: ______________

Medicaid Provider#_ ____________ PTAN #_____________ *optional*

Prescriber Phone: ______________

Practice/Facility Name: ______________________________

Facility Street Address: ______________________________

City: ______________ State: ______ ZIP Code: _________

Office Contact Name: (First) ______________ (Last) ______________

Office Contact Phone: ___________ Fax: ______________

Email: ______________________________

PATIENT CLINICAL INFORMATION

Patient Diagnosis(es)/ICD-10-CM: ______________________________

Does Patient Currently Have Nasal Polyps? ☐ Yes ☐ No

Date of Last Ethmoid Sinus Surgery: ___ /___ /______

Date of Last Course of Oral Corticosteroids: ___ /___ /______

Total number of prior sinus surgeries: ______________________________

Additional Medical Therapies Attempted and Failed for this Diagnosis in the Past 6 Months:

☐ Antibiotics ☐ Compounded Rinses ☐ Nasal Sprays ☐ Inhalers ☐ Other ______________________________

Additional Medications Taken? ______________________________

Does Patient Have Co-Morbid Conditions? ○ No ○ Yes *(Please check all that apply)*

☐ Asthma ☐ Allergies ☐ Mood Disorders ☐ Glaucoma ☐ Diabetes ☐ Bone Disease

Known Allergies: ______________________________ Other Conditions: ______________________________

Treatment Sites: ○ Left Ethmoid Sinus ○ Right Ethmoid Sinus ○ Bilateral

PRESCRIPTION INFORMATION

○ **UNILATERAL** — **SINUVA (mometasone furoate) sinus implant, 1350 mcg Qty 1 [To be inserted by physician. Route: Intrasinal]**

○ **BILATERAL** — **SINUVA (mometasone furoate) sinus implant, 1350 mcg Qty 2 [To be inserted by physician. Route: Intrasinal]**

PATIENT INSURANCE INFORMATION

Please provide a copy of the front and back of the patient's medical and prescription cards

If the patient has Medicare, please check all that apply: ☐ Part B ☐ Medicare Advantage

Medical Insurance Company: ______________________________

Name of Insured (Cardholder) : ______________________________

Policy #: ______________ Group #: ______________

Plan Phone: ______________

Member ID #: ______________________________

Prescription Drug Plan Name: ______________________________

Name of Insured (Cardholder) : ______________________________

Policy #: ______________ Group #: ______________

Plan Phone: ______________

BIN #: ______________ PCN #: ______________

PRESCRIBER ATTESTATION

Prescriber Signature: ______________________________ Date of Signature (mm/dd/yyyy): ___ /___ /______

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By my signature I also acknowledge that I have obtained a signed HIPAA authorization to release the patient's health information and such other information as may be required to ASCENT Reimbursement Support Program, its affiliates and Intersect ENT to assist in obtaining coverage for the product selected above and to assist in initiating the above 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. By my signature above, I also appoint ASCENT Reimbursement Support Program and its affiliates, on my behalf, to convey this prescription to the pharmacy for dispensing and for the pharmacy to dispense per its customary and usual procedures. I further certify that **(a)** any service provided through ASCENT Reimbursement Support Program and its affiliates on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use the above therapy or any other ASCENT Reimbursement Support Program and its affiliates product or service for anyone, and **(b)** my decision to prescribe the above therapy was based solely on my determination of medical necessity as set forth herein.

Mail us at
ASCENT Reimbursement Support
2250 Perimeter Park Drive, Suite 300
Morrisville, North Carolina 27560

Call us at
1-833-4-SINUVA (1-833-474-6882)
Monday - Friday, 8 AM - 8 PM ET

Fax us at
1- 844-745-2358

© 2018 Intersect ENT. All rights reserved.

Last updated September 2018.
MPM-11076 1.0