SINUVA®
(mometasone furoate) sinus implant

ASCENT

Patient Enrollment Form

Check Preferred Specialty Pharmacy ☐ Gentry ☐ Noble

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 the 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? ☐ No ☐ Yes *(Please check all that apply)*

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

Known Allergies: _____ Other Conditions: _____

PRESCRIPTION

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

☐ **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]

PRESCRIBER INFORMATION

Prescriber Name: _____ Prescriber Tax ID #: _____

DEA #: _____ State License #: _____ NPI #: _____

Medicaid Provider #: _____ PTAN #: _____

Prescriber Phone: _____ Practice/Facility Name: _____

Practice Street Address: _____

City: _____ State: _____ Zip Code: _____

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

Office Contact Phone: _____ Fax: _____

Office Contact Email: _____

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.

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

Fax completed form to **1- 844-745-2358.**