SINUVA™ (mometasone furoate) sinus implant

Specialty Pharmacy Enrollment Form

intersect® ENT

SPECIALTY PHARMACIES

Please select one of the following Specialty Pharmacies. This form will serve as the patients prescription for SINUVA.

☐**Noble Health Services** Phone: 866-575-8780 Fax: 888-842-3977

☐**Gentry Health Services** Phone: 833-858-7788 Fax: 800-662-8106

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# ______________________________

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 *(Please provide relevant chart notes to support approval of SINUVA)*

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

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: ___ /___ /______

Medical Therapies Attempted and Failed for this Diagnosis in the Past 6 Months (please list): ______________________________

____

Does Patient Have Co-Morbid Conditions? ☐ No ☐ Yes *(if Yes, please list)* ______________________________

____

Known Allergies: ______________________________

Other Conditions: ______________________________

PRESCRIPTION INFORMATION *SINUVA (mometasone furoate) sinus implant, 1350 mcg*

Rx SINUVA™ **Route:** Intrasinal **Quantity:** ☐ **1 (unilateral)** ☐ **2 (bi-lateral)** **Refills:** 0

SIG: To be inserted one time by prescriber

(Signature)______________________ Date ___ /___ /______
Dispense as Written

(Signature)______________________ Date ___ /___ /______
Product Substitution Permitted

PATIENT INSURANCE INFORMATION *(Please provide a copy of the front and back of the patient's medical and prescription cards)*

Medical Insurance Company: ______________________________

Name of Insured (Cardholder) : ______________________________

Policy #: ______________ Group #: ______________

Plan Phone: (___) ___-_______

Member ID #: ______________________________

Prescription Drug Plan Name: ______________________________

Name of Insured (Cardholder) : ______________________________

Policy #: ______________ Rx Group #: ______________

Plan Phone: (___) ___-_______

BIN #: ______________ PCN #: ______________

PRESCRIBER ATTESTATION

Prescriber Signature: ______________________________ Date ___ /___ /______

By my signature, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

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