PROPEL™

mometasone furoate sinus implant

Phone: 1-833-474-6882
Monday – Friday, 8 a.m. – 8 p.m. ET

PATIENT ENROLLMENT FORM for PROPEL™

○ **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:

PRESCRIPTION INFORMATION

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

☐ J32.0 Chronic maxillary sinusitis
☐ J32.1 Chronic frontal sinusitis
☐ J32.2 Chronic ethmoidal sinusitis
☐ J32.4 Chronic pansinusitis
☐ J32.8 Other chronic sinusitis
☐ J32.9 Chronic sinusitis, unspecified
☐ Other: _____

☐ PROPEL™
☐ PROPEL™ Mini
☐ PROPEL™ Mini SDS
☐ PROPEL™ Contour

Tried and failed sinus therapies:

☐ Topical Nasal Corticosteroids
☐ Antibiotics
☐ Budenoside Nasal Rinse
☐ Nasal Decongestants
☐ Other Nasal Rinses:
☐ Other _____

Known Allergies: Other Conditions:

Make sure to fill out the quantity of PROPEL™, either unilateral or bilateral.

☐ UNILATERAL
(mometasone furoate sinus implant, 370 mcg)

- ☐ Ethmoid
- ☐ Frontal
- ☐ Maxillary

☐ BILATERAL
(mometasone furoate sinus implant, 370 mcg)

- ☐ Ethmoid
- ☐ Frontal
- ☐ Maxillary

Please include a copy of the patient's insurance card and relevant chart notes along with the PROPEL™ Enrollment Form.

SERVICES REQUESTED

☐ Benefit Verification + Prior Authorization Assistance

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: ☐ Physician Office

PRESCRIBER SIGNATURE

(Ensure the Patient Enrollment Form is signed and dated before submitting. The signature must match the prescriber name listed above.)

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 ConnectiveRx, to Medtronic 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 PROPEL™ 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, and (2) authorization is voluntary and refusal to consent will not affect the patient's ability to obtain treatment or insurance benefits. I authorize Medtronic and its agents, to share information about the patient on my behalf to convey this request to the insurance payor for fulfillment.

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