XYREM®REMS PROGRAM PATIENT ENROLLMENT FORM

XYREM (sodium oxybate) oral solution 0.5 g/mL

XYREM® (sodium oxybate) oral solution

Fax completed form to XYREM REMS Program: 1-866-470-1744 (toll free)
OR mail to: XYREM REMS Program, PO Box 66589, St. Louis, MO 63166-6589.
For more information, call the XYREM REMS Program at 1-866-997-3688 (toll free).

Please Print (*denotes required field)

Patient Information

*FIRST NAME:	M.I.:	*LAST NAME:	*PRIMARY PHONE:
*DATE OF BIRTH (MM/DD/YYYY):		*GENDER: ○ M ○ F	CELL PHONE:
*ADDRESS:			WORK PHONE:
*CITY:	*STATE:	*ZIP CODE:	E-MAIL:

Insurance Information

DOES PATIENT HAVE PRESCRIPTION COVERAGE?	○ YES (Provide photocopy of both sides of Insurance Identification Card with this form)	○ NO
POLICY HOLDER'S NAME:		POLICY HOLDER'S DATE OF BIRTH:
INSURANCE COMPANY NAME:		RELATIONSHIP TO PATIENT:
INSURANCE PHONE:	RxID No.:	RxGrp No.:
RxBIN No.:	RxPCN No.:	

Prescriber Information

*FIRST NAME:	M.I.:	*LAST NAME:	*DEA No.:
*STREET ADDRESS:			*PHONE:
*CITY:	*STATE:	*ZIP CODE:	*FAX:
OFFICE CONTACT:	OFFICE CONTACT PHONE:		*NPI No.:

PATIENT: FORM MUST BE SIGNED BEFORE ENROLLMENT CAN BE PROCESSED.

By signing below, I acknowledge that:

- **My doctor/prescriber has counseled me on the serious risks and safe use of XYREM**
- **I have asked my doctor/prescriber any questions I have about XYREM**

***Patient/Guardian Signature:** _____ ***Date:** _____

***Printed Guardian Name (if applicable):** _____

PRESCRIBER: FORM MUST BE SIGNED BEFORE ENROLLMENT CAN BE PROCESSED.

By signing below, I acknowledge that:

- **I have counseled the patient about the serious risks associated with the use of XYREM and the safe use conditions as described in the XYREM REMS Program Patient Quick Start Guide**
  - ☐ **I have provided the patient with the XYREM REMS Program Patient Quick Start Guide (optional)**

***Prescriber Signature:** _____ ***Date:** _____