XYREM REMS PROGRAM PATIENT ENROLLMENT FORM

XYREM® (sodium oxybate) oral solution 0.5 g/mL

Complete and submit form online at www.XYREMREMS.com, OR scan and e-mail to XYREMPrescribers@express-scripts.com, OR fax to XYREM REMS Program at 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)

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 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: _____

Caregiver Name: _____ Relationship to Patient: _____ Caregiver Phone (if different than above): _____

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 (MM/DD/YYYY): _____

Insurance Company Name: _____ Relationship to Patient: _____

Insurance Phone: _____ RxID No.: _____ RxGrp No.: _____

RxBIN No.: _____ RxPCN No.: _____

Patient/Caregiver: 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/Caregiver Signature: _____ *Date: _____**

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

Prescriber: Form must be signed before enrollment can be processed.

By signing below, I acknowledge that:

- I have counseled the patient and/or caregiver 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 (for adult patients) or the XYREM REMS Program Brochure for Pediatric Patients and their Caregivers (for pediatric patients)
  - ☐ I have provided the patient and/or caregiver with the appropriate educational material [XYREM REMS Program Patient Quick Start Guide (for adult patients) and XYREM REMS Program Brochure for Pediatric Patients and their Caregivers (for pediatric patients)] (optional)

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

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