

# XYREM REMS PROGRAM PATIENT ENROLLMENT FORM

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



Complete and submit form online at [www.XYREMRMS.com](http://www.XYREMRMS.com), OR scan and e-mail to [XYREMPrescribers@express-scripts.com](mailto: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: <input type="checkbox"/> M <input type="checkbox"/> 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?	<input type="checkbox"/> Yes (provide photocopy of both sides of insurance identification card with this form)	<input type="checkbox"/> 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: \_\_\_\_\_