

XYREM REMS PROGRAM PATIENT ENROLLMENT FORM

XYREM[®] (sodium oxybate) oral solution 500 mg/mL



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: <input type="checkbox"/> M <input type="checkbox"/> F		CELL PHONE:
*ADDRESS:			WORK PHONE:
*CITY:	*STATE:	*ZIP CODE:	E-MAIL:

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:
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: _____