

**SODIUM OXYBATE REMS PROGRAM
PATIENT ENROLLMENT FORM**
Sodium oxybate oral solution 500 mg/mL

Sodium Oxybate
REMS Program

Complete this form through www.SodiumOxybateREMSProgram.com,
OR fax completed form to the Sodium Oxybate REMS Program at 800-353-0987 (toll free),
OR mail to: Sodium Oxybate REMS Program, PO Box XXXXX, City, ST XXXXX-XXXX.
For more information, please call the Sodium Oxybate REMS Program at 855-705-2424.

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:	EMAIL:
*MEDICATIONS: (list all known current prescription and non-prescription medications and dosages or submit as a separate page) <input type="checkbox"/> Check box if separate page attached			
Insurance Information			
Does Patient Have Prescription Coverage? <input type="checkbox"/> Yes (Please 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 sodium oxybate
- I have asked my doctor/prescriber any questions I have about sodium oxybate
- I understand that my personally identifiable information provided above will be shared with the Sodium Oxybate REMS Program, its agents, contractors, and affiliates, and entered into a patient database for the Sodium Oxybate REMS Program
- I understand that my personally identifiable information provided above will be shared with other sodium oxybate REMS programs, its agents, contractors, and affiliates

*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 sodium oxybate and the safe use conditions as described in the *Sodium Oxybate REMS Program Patient Quick Start Guide*
 I have provided the patient with the *Sodium Oxybate REMS Program Patient Quick Start Guide* (optional)

*Prescriber Signature: _____ *Date: _____