



XYWAV and XYREM REMS PATIENT ENROLLMENT FORM

XYWAV™ (calcium, magnesium, potassium, and sodium oxybates) oral solution, 0.5 g/mL
 XYREM® (sodium oxybate) oral solution 0.5 g/mL

Complete and submit form online at www.XYWAVXYREMREMS.com, OR scan and e-mail to ESSDSPrescribers@express-scripts.com, OR fax to XYWAV and XYREM REMS at 1-866-470-1744 (toll free), OR mail to: XYWAV and XYREM REMS, PO Box 66589, St. Louis, MO 63166-6589.
 For more information, call the XYWAV and XYREM REMS at 1-866-997-3688 (toll free).

Note: Use this form to enroll patients in the XYWAV and XYREM REMS for either product.

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 XYWAV and XYREM
- I have asked my doctor/prescriber any questions I have about XYWAV and 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 XYWAV and XYREM and the safe use conditions as described in the XYWAV or XYREM Patient Quick Start Guide (for adult patients) or the XYWAV or XYREM Brochure for Pediatric Patients and their Caregivers (for pediatric patients)
- I have provided the patient and/or caregiver with the appropriate educational material [XYWAV or XYREM Patient Quick Start Guide (for adult patients) and XYWAV or XYREM Brochure for Pediatric Patients and their Caregivers (for pediatric patients) (optional)]

▶ *Prescriber Signature: _____ *Date: _____