LUMRYZ™ REMS | Patient Enrollment Form

Lumryz
(sodium oxybate) for extended-release oral suspension

Complete and submit this form online at www.LUMRYZREMS.com, OR fax to 1-877-206-3198 (toll free).

For more information, please call the LUMRYZ REMS at 1-877-453-1029.

In order to receive LUMRYZ, patients must be enrolled in the LUMRYZ REMS. To enroll a patient, the prescriber and the patient must complete, sign and submit this form to the LUMRYZ REMS.

To help expedite the enrollment process, please complete all required fields - please print (*denotes required field)

PATIENT INFORMATION

*First Name:	M.I.:	*Last Name:	*Primary Phone:
*Date of Birth (MM/DD/YYYY):	*Gender (select one): ☐ Male ☐ Female ☐ Other		Cell Phone:
*Address Line 1:			Work Phone:
Address Line 2:			
*City:	*State:	*Zip Code:	*Email:

REMS for Oxybate Products Participation

Is the patient currently enrolled in other REMS for oxybate products? ☐ Yes ☐ No

Was the patient previously enrolled in other REMS for oxybate products? ☐ Yes ☐ No

PRESCRIBER INFORMATION

*First Name:	*Last Name:	
*DEA No.:	*NPI No.:	
*Address Line 1: 1151 Old York Road	Address Line 2: Suite 200	
*City: Abington	*State: PA	*Zip Code: 19001
*Phone: 215-957-9250	*Fax: 215-957-9254	

PATIENT ATTESTATIONS:

Before I start treatment, I must:

- Review the **Patient Brochure**
- Receive counseling from my doctor/prescriber about the serious risks with LUMRYZ and the safe use, handling, and storage of LUMRYZ using the **Patient Brochure**
- Enroll in the REMS by completing the **Patient Enrollment Form** with my prescriber
- Complete the **Patient Counseling Checklist** with the pharmacist

During treatment

- Follow the safe use instructions explained to me by my doctor/prescriber
- Tell my pharmacist about any changes in the medicines I am taking and any changes in my medical history so I can be monitored for problems with the medicines I'm taking and signs of abuse and misuse of LUMRYZ

At all times

- I understand that my personally identifiable information provided above will be shared with the LUMRYZ REMS, its agents, contractors, and affiliates, and entered into a patient database for the LUMRYZ REMS
- I understand that my personally identifiable information provided above may be shared with other REMS for oxybate salt medicines, their agents, contractors, and affiliates
- I agree that Avadel CNS Pharmaceuticals, LLC and its agents may contact me or my doctor/prescriber via phone, mail, or email to support administration of the LUMRYZ REMS
- I agree to inform my doctor/prescriber and pharmacy about changes in my medication use or medical history

_____ *Patient/Guardian Signature

_____ *Date

* Printed Guardian Name, if applicable: First Name: _____ Last Name: _____

* Guardian Email, if applicable: _____

PRESCRIBER:

By signing below, I acknowledge that:

- I have counseled the patient about the serious risks associated with the use of LUMRYZ and the safe use conditions as described in the **Patient Brochure**
- I have provided the patient with the **Patient Brochure** (optional)

_____ *Prescriber Signature

_____ *Date

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Avadel