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: 1151 Old York Road, Suite 200 *Phone: 215-957-9250

*City: Abington *State: PA *Zip Code: 19001 *Fax: 215-957-9254

Office Contact: _____ Office Contact Phone: _____ *NPI No: _____

Patient Information

*First Name: _____ M.I.: _____ *Last Name: _____ *Primary Phone: _____

*Date of Birth (MM/DD/YYYY): _____ *Gender: ☐ M ☐ 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? ☐ Yes (provide photocopy of both sides of insurance identification card with this form) ☐ 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 or XYREM
- I have asked my doctor/prescriber any questions I have about XYWAV or XYREM
- I understand that my doctor/prescriber has prescribed either XYWAV or XYREM for my treatment or the treatment of the child I am providing care for.

Before I start treatment, I will:
- Review the XYWAV or XYREM **Patient Quick Start Guide** or XYWAV or XYREM **Brochure for Pediatric Patients and their Caregivers**
- Receive counseling from my doctor/prescriber about the serious risks of XYWAV or XYREM and the safe use, handling, and storage of XYWAV or XYREM using either the XYWAV or XYREM **Patient Quick Start Guide** or XYWAV or XYREM **Brochure for Pediatric Patients and their Caregivers**
- Enroll in the XYWAV and XYREM REMS by completing the XYWAV and XYREM **Patient Enrollment Form** with my doctor/prescriber
- Complete the **Patient Counseling Checklist** with the pharmacist

During treatment, I will:
- Follow the safe use rules described in the XYWAV or XYREM **Patient Quick Start Guide** or XYWAV or XYREM **Brochure for Pediatric Patients and their Caregivers**
- Complete the Patient Counseling Checklist with the pharmacist as required
- Be monitored by my doctor/prescriber as required

At all times:
- I agree to inform my doctor/prescriber and pharmacy about new medications or medical conditions

*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 informed the patient and/or caregiver that the XYWAV and XYREM REMS will send 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) to him or her

*Prescriber Signature: _____ *Date: _____