PATIENT ENROLLMENT FORM AND PRESCRIPTION FORM

Xyrem® (sodium oxybate) Oral Solution 500 mg/mL

XYREM® (sodium oxybate) oral solution
SUCCESS PROGRAM® for physicians

Prescriber Information

Prescriber's Name:	Office Contact:	
Street Address:		
City:	State:	Zip:
Phone:	Fax:	
License Number:	DEA Number:	
Email:		

Patient Information

Patient Name:	SS#:
DOB:	Sex:
Address:	City:
State:	Zip:
Best time to Contact:	Phone:
Alternate Phone:	Email:

Insurance

Insurance Company Name:	Phone #:
Insured's Name:	Relationship to Patient:
Identification number:	Policy/Group Number:

Prescription Card Attached: ☐ **Yes** ☐ **No**

Dosing

Total Nightly Xyrem Dose: _____gms	**Xyrem 0.5 gms/mL**
Split total nightly dose into two separate doses	
First Dose: Take _____gms p.o. diluted in ¼ cup (4 tbsp) of water at bedtime	**Second dose**: Then take _____gms p.o. diluted in ¼ cup (4 tbsp) of water again 2 ½ to 4 hours later.
Example dosing schedule: 6 gms total nightly dose = 3 gms Xyrem mixed in ¼ cup of water to take at bedtime and 3 gms Xyrem mixed in ¼ cup of water to take 2 ½ to 4 hrs later. (NOTE: prepare both doses at the same time at bedtime)	
Refills: 0 1 2 3 4 5 (circle one)	**Total Quantity:** _____ month supply

Special Instructions

(check boxes for initial prescription only)

☐ I verify that the patient has been educated on Xyrem preparation, dosing, and scheduling (required)

☐ I verify that the patient has received his/her own copy of the Patient Success Program Materials (optional)

Xyrem is medically appropriate for this patient.

Prescriber Signature (required) _____ **Date** ___/___/_____

Fax completed form to Xyrem Success Program (toll-free) 1-866-470-1744
For information, call the Xyrem Team (toll-free) at 1-866-XYREM88 (1-866-997-3688)