



(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): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 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: | Address Line 2: | |
| *City: | *State: | *Zip Code: |
| *Phone: | *Fax: | |

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