For NUZYRA Pharmacy Network completion: ❑ Bridge Only ❑ PAP Only

TO ORDER NUZYRA® (omadacycline)

NUZYRA is available to order through the NUZYRA Pharmacy Network, including CVS, Option Care, PANTHERx, and Walgreens. For a complete list, scan the QR code or please visit our website at **www.nuzyra.com/hcp/pharmacy-finder**.

- Complete the entire form, including all the required fields (*)
- Fax this form to the nearest participating pharmacy

SCAN THIS QR CODE

PATIENT SUPPORT ENROLLMENT FORM

- Complete the entire form, including all the required fields (*), and fax pages to 1-617-807-6696

NUZYRA Central™ provides:

- Reimbursement support
- Patient resources
- Affordability program

Phone: 1-877-4-NUZYRA (1-877-468-9972) **Fax:** 1-617-807-6696
Hours of Operation: Mon-Fri, 9 AM to 8 PM ET
Website: www.nuzyra.com/hcp/nuzyra-central

Patient Discharge Date: _____

Patient Information

*Patient Last Name: _____ *Patient First Name: _____

*Gender: Female ____ Male ____ *DOB: _____ SSN #: _____ Email: _____

*Address: _____ *City: _____

*State: _____ *ZIP Code: _____ *Phone #: _____ Alt Phone #: _____

*Shipping Address (if different from above): _____

Patient Insurance Information

*Primary Insurance Name: _____ *Primary Insurance Phone: _____

*Policy ID #: _____ *Group #: _____ *Policyholder Name: _____

*Relationship to Patient: _____ *Policyholder DOB: _____

Secondary Insurance Name: _____ Secondary Insurance Phone: _____

Policy ID #: _____ Group #: _____ Policyholder Name: _____

Relationship to Patient: _____ Policyholder DOB: _____

Pharmacy: _____

Clinical Information

*Primary Diagnosis/ICD-10-CM: _____ Secondary Diagnosis/ICD-10-CM: _____

History of therapies tried/failed, if applicable (please include dates): _____

_____

Healthcare Provider/Facility Information

*Prescriber Name: _____ *NPI #: _____ *Tax ID #: _____

*Facility Name: _____ Address: _____

*Contact Name/Title: _____ City/State/ZIP: _____

Email: _____ *Phone: _____ *Fax: _____

Prescription/Order Information

*Patient DOB: _____ *Patient Last Name: _____ *Patient First Name: _____

*Product: NUZYRA 150 mg Tablets

❑ Loading Dose Required
Route of Administration: PO
450 mg once daily x 2 days
300 mg once daily x ____ days
Refills: _____

❑ NO Loading Dose Required
Route of Administration: PO
300 mg once daily x ____ days

Refills: _____

*Product: NUZYRA 100 mg IV

❑ IV
Quantity: _____
Days Supply: _____
Route of Administration: _____
Directions: _____
Refills: _____

*Drug Allergies: ____ No ____ Yes (if yes, please list medication(s)): _____

*Patient's Concurrent Medications: _____

Prescriber Signature Required for Prescription Orders

I certify that the information provided in this Patient Support Enrollment Form is complete and accurate to the best of my knowledge. By signing this Patient Support Enrollment Form, I certify that I have prescribed NUZYRA based on my professional judgment of medical necessity and that I will supervise the patient's medical treatment. I authorize Paratek Pharmaceuticals, Inc. ("Paratek"), The Lash Group, LLC ("Lash") and/or any pharmacy in the limited distribution network of pharmacies that are authorized by Paratek to dispense NUZYRA ("Network Pharmacy") to provide any information on this form or any other medical information provided by me to Paratek, Lash and/or Network Pharmacy to the insurer of the named patient and to forward the above prescription, by fax or by other mode of delivery, to the pharmacy chosen by the named patient.

SIGN AND DATE → Prescriber Signature: _____ Date: _____

NPI #: _____

❑ Dispense as Written ❑ Substitution Permissible

Special Note: In addition to completing this section, NY Prescribers must submit a Rx on an original NY Rx blank

Bridge Prescription/Order Information (optional)

Patient DOB: _____ Patient Last Name: _____ Patient First Name: _____

Product: NUZYRA 150 mg Tablets

❑ Loading Dose Required
Route of Administration: PO
450 mg once daily x 2 days

❑ NO Loading Dose Required
Route of Administration: PO
300 mg once daily x 2 days

Prescriber Signature Required for Prescription Orders

I certify that the information provided in this Patient Support Enrollment Form is complete and accurate to the best of my knowledge. By signing this Patient Support Enrollment Form, I certify that I have prescribed NUZYRA based on my professional judgment of medical necessity and that I will supervise the patient's medical treatment. I authorize Paratek Pharmaceuticals, Inc. ("Paratek"), The Lash Group, LLC ("Lash") and/or any pharmacy in the limited distribution network of pharmacies that are authorized by Paratek to dispense NUZYRA ("Network Pharmacy") to provide any information on this form or any other medical information provided by me to Paratek, Lash and/or Network Pharmacy to the insurer of the named patient and to forward the above prescription, by fax or by other mode of delivery, to the pharmacy chosen by the named patient.

SIGN AND DATE → Prescriber Signature: _____ Date: _____

Special Note: In addition to completing this section, NY Prescribers must submit a Rx on an original NY Rx blank

Patient Authorization and Release

I authorize my healthcare provider(s), health plan(s) and pharmacy(ies) to disclose my personal Protected Health Information (PHI) such as my name, address, information related to my medical condition, treatment, care management, health insurance information, payment/benefit information as well as information provided on this form and any prescription to Paratek Pharmaceuticals, Inc. ("Paratek"), The Lash Group, LLC ("Lash") and/or any pharmacy in the limited distribution network of pharmacies that distribute NUZYRA ("Network Pharmacy") and their agents and affiliates for therapy support, other products and services and to contact me by mail and/or phone to request more information about my experience with NUZYRA. I also authorize Paratek, Lash, Network Pharmacy and their agents and affiliates to use this information to provide reimbursement support. I understand that Lash and/or Network Pharmacy may receive remuneration for the use or disclosure of my information pursuant to this authorization. Although Paratek, Lash, Network Pharmacy and their agents and affiliates will safeguard my PHI and only use it for intended purposes, I understand it may be subject to re-disclosure and no longer be protected by federal privacy laws. My right to treatment, payment for treatment and eligibility/enrollment for insurance benefits is not conditioned on signing. However, if I refuse to sign this authorization or revoke my authorization, I understand that this means I will not be able to receive therapy support and reimbursement support from Paratek, Lash and their agents and affiliates related to my prescription for NUZYRA. This authorization will remain in effect unless I revoke it in writing by mailing a letter to Paratek Pharmaceuticals, Inc., 75 Park Plaza 4th Floor, Boston, MA 02116, Attn: General Counsel, except to the extent that action has already been taken in reliance on it. I am entitled to receive a copy of this authorization.

The personal and health insurance information I have provided on this form is complete and accurate to the best of my knowledge. I will update my information promptly if any of the information reflected on this form changes by contacting NUZYRA Central™ at 1-877-4NUZYRA (1-877-468-9972). This authorization allows those who rely upon it to release my personal protected health information for 3 years from the date of my signature.

Patient Signature: _____ Date: _____

PARATEK