



# TO PRESCRIBE NUZYRA® (omadacycline)

NUZYRA is available through Network Pharmacies, including: CVS, Walgreens, Kroger, Option Care, and PANTHERx. For a complete list, scan the QR code or visit our website at [www.nuzyra.com/hcp/pharmacy-finder](http://www.nuzyra.com/hcp/pharmacy-finder).

**Option 1:** e-prescribe with the patient's clinical notes, include ICD-10 code(s) and dosing

**Option 2:** Complete the entire form and fax to a participating pharmacy

Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ NCPDP #: \_\_\_\_\_



**QUESTIONS?** Call **NUZYRA Central™ Support Services** at **1-877-4-NUZYRA (1-877-468-9972)**, Mon-Fri, 8 AM to 8 PM ET to speak with a representative.

If your patient has difficulty affording NUZYRA, they may be eligible for assistance. Complete the entire form and fax to NUZYRA Central at (617) 807-6696.

Date Requested: \_\_\_\_\_ Ship to:  Patient  Office  Other: \_\_\_\_\_

## Patient Information

\*Patient Last Name: \_\_\_\_\_ \*Patient First Name: \_\_\_\_\_  
 \*Gender: Female \_\_\_\_\_ Male \_\_\_\_\_ \*DOB: \_\_\_\_\_ 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:  
 J18.9 Pneumonia  L08.9 Local infection of the skin and subcutaneous tissue  
 Other Code: \_\_\_\_\_ Description: \_\_\_\_\_  
 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

### CABP

Loading Dose

Route of Administration: PO

300 mg twice on day 1

300 mg once daily x \_\_\_\_\_ days

Refills: \_\_\_\_\_

### ABSSSI

Loading Dose

Route of Administration: PO

450 mg once daily x 2 days

300 mg once daily x \_\_\_\_\_ days

Refills: \_\_\_\_\_

NO Loading Dose

Route of Administration: PO

300 mg once daily x \_\_\_\_\_ days

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

*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

### CABP

Loading Dose

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Loading Dose

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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: \_\_\_\_\_

**Special Note: If you are unable to obtain a patient signature the NUZYRA Central Team will obtain one verbally when contacting the patient**

