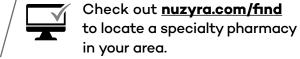


## TO PRESCRIBE NUZYRA® (omadacycline) VIA FAX

Complete this form in its entirety and fax to a network specialty pharmacy. To ensure timely delivery to the patient and minimize callbacks from the pharmacy, be sure to include; ICD-10 codes and any other information the pharmacy will need to fill the prescription.

## **Network Specialty Pharmacies include:** Perigon Pharmacy 360, Walgreens Specialty, CVS Specialty, Kroger Specialty, PANTHERx, and Option Care



\*Fax:

Paratek Pharmaceuticals, inc. aoes not recommo of one pharmacy over another.	end or prefer the use
All fields marked with * are mandatory	4
Pharmacy Name:	Address:
City: State: Cell Pho	ne #: _() Fax: _()NCPDP #:
Date Requested:	Ship to: □ Patient □ Office □ Other:
Or attach Face Sheet	Patient Information t   Demographics page if all of the below information is included
*Patient Last Name:	*Patient First Name:
*Gender: Female Male *DO	B: Email:
*Address:	*City:
*State: *ZIP Code:	*Cell Phone #: Alt Phone #:
*Shipping Address (if different from ab	pove):
Or attach Face Sheet	Patient Insurance Information t   Demographics page if all of the below information is included
*Primary Insurance Name:	*Primary Insurance Phone:
	oup #: *Policyholder Name:
	*Policyholder DOB:
Secondary Insurance Name:	Secondary Insurance Phone:
Policy ID #: Grou	p #:Policyholder Name:
	Policyholder DOB:
	Clinical Information
Access billing & coding resources of	at www.nuzyra.com/hcp/billing-and-coding/
*Primary Diagnosis/ICD-10-CM:	
☐ J18.9 Pneumonia	lue LO8.9 Local infection of the skin and subcutaneous tissue
Other Code:	Description:
History of antibiotic therapies tried/f	ailed, if applicable (please include dates):
Не	ealthcare Provider/Facility Information
*Prescriber Name:	*NPI #:*DEA #:
	Address:
*Contact Name/Title:	City/State/ZIP:

\_ \*Cell Phone: \_

Prescription/Order Information		
*Patient DOB:*Pati	ent Last Name:	*Patient First Name:
*Product: <u>NUZYRA 150 mg Tablet</u>	<u>.s</u>	
	ABSSSI  Loading Dose Route of Administration: PO 450 mg once daily x 2 days 300 mg once daily x days Refills:	
NPI #:  Dispense as Written  Special Note: In addition to comp	e:	t submit a Rx on an original NY Rx blank
	•	•
	ent Last Name:	Patient First Name:
Product: NUZYRA 150 mg Tablets  CABP  Loading Dose Route of Administration: PO 300 mg twice on day 1  Prescriber Signature Required for Prescri	ABSSSI ☐ Loading Dose Route of Administration: PO 450 mg once daily x 2 days	☐ NO Loading Dose Route of Administration: PO 300 mg once daily x 2 days
OLON!		
Prescriber Signatur	e:	Date:
Special Note: In addition to comp	leting this section, NY Prescribers must	t submit a Rx on an original NY Rx blank

THIS FORM IS ONLY FOR A PRESCRIPTION AND IS NOT FOR PATIENT SERVICES.

THIS PRESCRIPTION FORM SHOULD BE FAXED TO A NETWORK SPECIALTY PHARMACY.

All Patient Assistance Program requests from HCPs, Specialty Pharmacies, and hospitals should use NUZYRA Central® e-submit.

nuzyra.com/nuzyracentral

