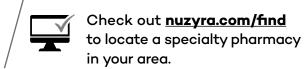


## TO PRESCRIBE NUZYRA® (omadacycline) VIA FAX

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, PANTHERx, and Option Care

Paratek Pharmaceuticals Inc. does not recommend or prefer the use



\*Fax:

of one pharmacy over another.	prefer the use
All fields marked with * are mandatory.	
Pharmacy Name:	Address:
City: State: Cell Phone #:	_()Fax: _()NCPDP #:
Date Requested:	Ship to: Patient Office Other:
Or attach Face Sheet   Dei	Patient Information mographics page if all of the below information is included
*Patient Last Name:	*Patient First Name:
*Gender: Female Male *DOB:	Email:
*Address:	*City:
*State: *ZIP Code:	*Cell Phone #: Alt Phone #:
*Shipping Address (if different from above):	
	atient Insurance Information mographics page if all of the below information is included
*Primary Insurance Name:	*Primary Insurance Phone:
	: *Policyholder Name:
*Relationship to Patient:	*Policyholder DOB:
	Secondary Insurance Phone:
Policy ID #: Group #: _	Policyholder Name:
Relationship to Patient:	Policyholder DOB:
	Clinical Information
Access billing & coding resources at ww	w.nuzyra.com/hcp/billing-and-coding/
*Primary Diagnosis/ICD-10-CM:	
☐ J18.9 Pneumonia	LO8.9 Local infection of the skin and subcutaneous tissue
☐ Other Code:	Description:
History of antibiotic therapies tried/failed,	if applicable (please include dates):
Health	care Provider/Facility Information
*Prescriber Name:	*NPI #:*DEA #:*
*Facility Name:	Address:
*Contact Name/Title:	City/State/ZIP:

\_ \*Cell Phone: \_

	Prescriptio	n/Order Information
*Patient DOB:	*Patient Last Name:	*Patient First Name:
*Product: <u>NUZYRA 150 m</u>	g Tablets	
CABP  □ Loading Dose  Route of Administration: 300 mg twice on day 1 300 mg once daily x  Refills:	450 mg once days 300 mg once	NO Loading Dose Route of Administration: PO daily x 2 days daily x days Refills:
*Drug Allergies: No	Yes (if yes, please list n	medication(s)):
*Patient's Concurrent Me	dications:	
☐ Dispense as Written Special Note: In addition		NY Prescribers must submit a Rx on an original NY Rx blank  Order Information (optional)
Dationt DOR:		Patient First Name:
Product: NUZYRA 150 mg		Patient First Name.
<b>CABP</b> ☐ Loading Dose  Route of Administration:  300 mg twice on day 1	ABSSSI  Loading Do  Route of Adm  450 mg once	NO Loading Dose  Route of Administration: PO  a daily x 2 days  NO Loading Dose  Route of Administration: PO  300 mg once daily x 2 days
Prescriber Signature Required	for Prescription Orders	
Prescriber S	ignature:	Date:
		NY Prescribers must submit a Rx on an original NY Rx blank
		The second of th

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

