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 of one pharmacy over another.

Check out **nuzyra.com/find** to locate a specialty pharmacy in your area.

All fields marked with * are mandatory.

Pharmacy Name: _____ Address: _____

City: _____ State: ____ Cell Phone #: _(____)_____-_____ Fax: _(____)_____-_____ NCPDP #: _____

Date Requested: _____ Ship to: ❑ Patient ❑ Office ❑ Other: _____

Patient Information

Or attach Face Sheet | Demographics 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): _____

Patient Insurance Information

Or attach Face Sheet | Demographics page if all of the below information is included

*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: _____

Clinical Information

Access billing & coding resources at www.nuzyra.com/hcp/billing-and-coding/

*Primary Diagnosis/ICD-10-CM:

❑ J18.9 Pneumonia

❑ L08.9 Local infection of the skin and subcutaneous tissue

❑ Other Code: _____ Description: _____

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

Healthcare Provider/Facility Information

*Prescriber Name: _____ *NPI #: _____ *DEA #: _____

*Facility Name: _____ Address: _____

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

Email: _____ *Cell 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

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
Route of Administration: PO
300 mg twice on day 1

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

Prescriber Signature Required for Prescription Orders

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

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

PARATEK®