

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: CVS Specialty, Walgreens Specialty, Kroger Specialty, and PANTHERx

Paratek Pharmaceuticals, Inc. does not recommend or prefer the use of one pharmacy over another.



Check out www.nuzyra.com/hcp/pharmacy-finder/ 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

 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

 Prescriber Signature: _____ Date: _____

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