



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 Caremark Specialty and Walgreens Specialty

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



Check out [nuzyra.com/find](https://www.nuzyra.com/find) to locate a specialty pharmacy in your area.

All fields marked with * are mandatory.



URGENT

Pharmacy Name: _____ Address: _____
City: _____ State: _____ Phone #: (____) _____ - _____ Fax: (____) _____ - _____
NCPDP #: _____ *State License #: _____
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.nuzyrahcp.com/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

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: _____

**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.

nuzyrahcp.com/eprescribe



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