


NUZYRA® (OMADACYCLINE) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

	Patient Name:		Date of Birth:		
	Address:				
	Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
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Nuzyra® (Omadacycline) Prescription

Choose One:

- Take 300 mg by mouth twice daily x 1 day and then 300 mg by mouth once daily thereafter x _____
- Take 450 mg by mouth once daily x 2 days and then take 300 mg by mouth once daily thereafter x _____ days.
- Infuse 200 mg IV over 60 minutes once x 1 day and then 300 mg by mouth once daily thereafter x _____ days.
- Infuse 200 mg IV over 60 minutes once x 1 day and then 100 mg IV over 30 minutes once daily thereafter x _____ days.
- Other: _____

Ancillary Orders (for IV Formulation Only)

Anaphylaxis Kit

If this is a 1st dose, would you like Option Care to provide an anaphylaxis kit with the 1st dose?

- Yes – please complete Anaphylaxis Physician Order (FR-PC-036) No

Pre-Medication Orders

- Other: _____

IV Flush Orders

- Peripheral: NS 2 to 3 mL pre-/post-use. Heparin (10 unit/mL) 1 to 3 mL post-use. For maintenance, heparin (10 unit/mL) every 24 hr.
- Peripheral-Midline: NS 3 to 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin (100 unit/mL) 3 mL post-use. For maintenance, heparin (100 unit/mL) 3 mL every 24 hr.
- PICC and Central Tunneled/Non-Tunneled: NS 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin (10 unit/mL) 5 mL or (100 unit/mL) 3 mL post-use. For maintenance, heparin (10 unit/mL) 5 mL or (100 unit/mL) 3 mL every 24 hr.
- Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL units post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

- No labs ordered at this time.
- Other: _____

Skilled nurse to administer doses intravenously (where applicable).

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

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