

NUZYRA® (OMADACYCLINE) PRESCRIBER ORDER FORM

Patient Name:

Date of Birth:

Address:

Phone:

Height:

☐ inches ☐ cm

Weight:

☐ lbs ☐ kg**Clinical Information**

Primary Diagnosis Description:

ICD-10 Code:

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 Health to provide an anaphylaxis kit with the 1st dose?

- ☐ **Yes** – please complete Anaphylaxis Physician Order ☐ **No**

Pre-Medication Orders

- ☐ Other: _____

IV Flush Orders

- ☐ Peripheral: 0.9% Sodium Chloride 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: 0.9% Sodium Chloride 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: 0.9% Sodium Chloride 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: 0.9% Sodium Chloride 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:

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

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