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:

