NUZYRA® (OMADACYCLINE) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
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).
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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: 713-983-4647

