COMPOUNDED PRESCRIPTION

Date

PRESCRIBER INFO

Prescriber Name		
Prescriber Address		
City	State	Zip
Prescriber Phone	DEA	NPI

PATIENT INFO

Patient Name		DOB
Patient Street Address		
City	State	Zip
Cell Phone	Email	
Drug Allergies		

RX INFO

Please Dispense:

SEMAGLUTIDE OTF (oral transmucosal films)

☐ **5 mg** ☐ **7.5 mg** ☐ **10 mg** ☐ **12.5 mg** ☐ **15 mg**

Qty: ☐ **8** ☐ **16** ☐ **24** ☐ **other** _____ **(multiple of 2)**

Sig: ☐ **Fold in half and apply one film strip to inner cheek/gumline twice a week (every 3-4 days)**

☐ **Fold in half and apply one film strip to inner cheek/gumline _____ times per week**

Refills: ☐ **None** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **12** ☐ **other** _____

ADDITIONAL RX

☐ **Phentermine 37.5 mg tabs***	**Qty:** _____	**Sig:** _____	**Refills:** _____
☐ **Phentermine SR caps _____ mg*** Available as 10mg, 20mg, or 30 mg	**Qty:** _____	**Sig:** _____	**Refills:** _____
☐ **Diethylpropion ER 75 mg***	**Qty:** _____	**Sig:** _____	**Refills:** _____
☐ **Phendimetrazine 35 mg***	**Qty:** _____	**Sig:** _____	**Refills:** _____
☐ **Phendimetrazine ER 105 mg***	**Qty:** _____	**Sig:** _____	**Refills:** _____
☐ **Topiramate _____ mg tabs** Available as 25mg, 50mg, 100mg, 200mg	**Qty:** _____	**Sig:** _____	**Refills:** _____

PRESCRIBER SIGNATURE

Prescriber Signature	Date/Time

This form has been provided by Premier Drugstore *Fax 770-675-7296*

**Preprinted Controlled Rxs must be verified by RPh by phone per DEA*