COMPOUNDED PRESCRIPTION ORDER

PRESCRIBER INFORMATION		
Practice Name		
Street Address		
City	State	Zip
Phone	Fax	

PATIENT INFORMATION		
Name		DOB
Street Address		
City	State	Zip
Phone	Email	
Allergies		

PHARMACY TO DISPENSE: SEMAGLUTIDE 2.5 MG/ML INJECTION

Please choose Sig:

▢	**Inject 20 UNITS (0.5 mg) subcutaneously once a week for 4 weeks**
▢	**Inject 40 UNITS (1 mg) subcutaneously once a week for 4 weeks**
▢	**Inject 60 UNITS (1.5 mg) subcutaneously once a week for 4 weeks**
▢	**Inject 80 UNITS (2 mg) subcutaneously once a week for 4 weeks**
▢	**Inject 100 UNITS (2.5 mg) subcutaneously once a week for 4 weeks**
▢	**Inject ________ UNITS subcutaneously once a week for 4 weeks**

Pharmacy to dispense appropriate volume and quantity of U-100 syringes/needles

Please choose vial size:

Check One	mL	# of Units	Total mg Per vial	Price
▢	1 mL	100	2.5 mg	$149
▢	2 mL	200	5 mg	$239
▢	3 mL	300	7.5 mg	$299
▢	5 mL	500	12.5 mg	$399

Vial expires 28 days after first puncture by patient

# of vials __________ Refills: __________

PRESCRIBER SECTION

I certify that the above patient does not have a family/personal history of Medullary Thyroid Cancer or a personal history of Multiple Endocrine Neoplasia.

Prescriber Name		
Prescriber Signature		
NPI	State Lic.	Date/Time

Form provided by Premier Drugstore - Fax to 770-675-7296