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	Sex	

PHARMACY TO DISPENSE: SEMAGLUTIDE 2.5 MG/ML INJECTION

Please choose Sig:

☐	**Inject 10 UNITS (0.25 mg) subcutaneously once a week for 4 weeks**
☐	**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**

Refills: _____ **Pharmacy to dispense appropriate volume and quantity of U-100 syringes/needles.**

DISPENSE: 1 MONTH SUPPLY

This table is for pharmacist reference. Prescriber does not need to fill out this section.

UNITS PER WEEK	VIAL SIZE TO DISPENSE	PRICE
10 - 25	1 mL	$149
26 - 50	2 mL	$239
51 - 75	3 mL	$299
< 76	5 mL	$399

Vial expires 28 days afte first puncture by patient

Shipping additional $25-$50 based on location

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 ***Lead time can be up to 7-14 days depending on drug availability***