Weight-Loss Protocol

Order Form

AREA RESERVED FOR PHARMACY

Premier Drugstore

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 2.5mg/mL (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

Quantity	☐ 1 month	Other:_____ (60 day max)	# of refills:____

Tirzepatide 5mg/0.5mL (please choose Sig:)

☐	Inject 25 UNITS (2.5 mg) subcutaneously once a week for 4 weeks
☐	Inject 50 UNITS (5 mg) subcutaneously once a week for 4 weeks
☐	Inject 75 UNITS (7.5 mg) subcutaneously once a week for 4 weeks
☐	Inject 100 UNITS (10 mg) subcutaneously once a week for 4 weeks
☐	Inject 125 UNITS (12.5 mg) subcutaneously once a week for 4 weeks
☐	Inject 150 UNITS (15 mg) subcutaneously once a week for 4 weeks
☐	Inject _____ UNITS subcutaneously once a week for 4 weeks

Quantity	☐ 1 month	Other:_____ (60 day max)	# of refills:____

Pharmacy Reference

Prescriber does not need to fill out this section. Dispense up to 60/day supply.

Semaglutide (max 10mL)	
Units/Week	Vial Size
10-25	1mL
26-50	2mL
51-75	3mL
76-100	2mL + 2mL
100+	3mL + 2mL

Tirzepatide (max 12mL)	
Units/Week	Vial Size
10-25	1mL
26-50	2mL
51-75	3mL
76-100	2mL + 2mL
101-125	2mL + 3mL
126+	3mL + 3mL

Vials expire 28 days after first puncture by patient. Pharmacy to dispense appropriate volume and quantity of U-100 syringes/needles.

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	Supervising Physician	NPI
Prescriber Signature		Date/Time

Send the completed form to the Premier Drugstore

Fax: 770-675-7296