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**

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

Refills: _____

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 after first puncture by patient

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 Robins Pharmacy fax to 478-333-6228