



## GLP-1 Order Form

608 S Houston Lake rd Warner Robins | GA 31088  
P: 478-333-6767 | F: 478-333-6228

### Prescriber Information

Practice Name:		
Street Address:		
City:	State:	ZIP:
Phone:	Fax:	

### Patient Information

Patient Name:	DOB:	
Street Address:		
City:	State:	ZIP:
Phone:		
Email:	Sex:	
Allergies:		

### Pharmacy To Dispense Semaglutide/Niacinamide/Cyanocobalamin

2.5/2/0.5 mg/mL (MDV)

(Please Select SIG:)

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | Inject 10 units (0.25 mg) SQ weekly for 4 weeks and titrate UD |
| <input type="checkbox"/> | Inject 20 units (0.5 mg) SQ weekly for 4 weeks and titrate UD  |
| <input type="checkbox"/> | Inject 40 units (1 mg) SQ weekly for 4 weeks and titrate UD    |
| <input type="checkbox"/> | Inject 60 units (1.5 mg) SQ weekly for 4 weeks and titrate UD  |
| <input type="checkbox"/> | Inject 70 units (1.75 mg) SQ weekly for 4 weeks and titrate UD |
| <input type="checkbox"/> | Inject 80 units (2 mg) SQ weekly for 4 weeks and titrate UD    |
| <input type="checkbox"/> | Inject 100 units (2.5 mg) SQ weekly for 4 weeks and titrate UD |
| <input type="checkbox"/> |  |

Quantity: 1 Month    Other: \_\_\_\_\_ (60 day max)    # of refills: \_\_\_\_\_  
Add your body text

### Tirzepatide/Niacinamide/Cyanocobalamin 10/2/0.5 mg/mL (MDV)

(Please Choose SIG:)

- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | Inject 25 units (2.5 mg) SQ weekly for 4 weeks and titrate UD   |
| <input type="checkbox"/> | Inject 50 units (5 mg) SQ weekly for 4 weeks and titrate UD     |
| <input type="checkbox"/> | Inject 75 units (7.5 mg) SQ weekly for 4 weeks and titrate UD   |
| <input type="checkbox"/> | Inject 100 units (10 mg) SQ weekly for 4 weeks and titrate UD   |
| <input type="checkbox"/> | Inject 125 units (12.5 mg) SQ weekly for 4 weeks and titrate UD |
| <input type="checkbox"/> | Inject 150 units (15mg) SQ weekly for 4 weeks and titrate UD    |
| <input type="checkbox"/> |   |

Quantity: 1 Month    Other: \_\_\_\_\_ (60 day max)    # of refills: \_\_\_\_\_

### Pricing

#### Semaglutide/Niacinamide/Cyanocobalamin

Dose	Units/wk	Vial Size	Price
0.25 mg	10	1 mL	\$149
0.5 mg	20	1 mL	\$149
1 mg	40	2 mL	\$239
1.5 mg	60	3 mL	\$299
2 mg	80-100	4 mL	\$349
2.5 mg	101+	5 mL	\$399

•Price Per Month

#### Tirzepatide/Niacinamide/Cyanocobalamin

Dose	Units/Wk	Viral Size	Price
2.5 mg	25	1 mL	\$199
5 mg	50	2 mL	\$249
7.5 mg	75	3 mL	\$299
10 mg	100	4 mL	\$349
12.5 mg	125	5 mL	\$399
15 mg	150	6 mL	\$449

•Price Per Month

### Prescriber Section

This formulation combines a GLP-1 receptor agonist with Vitamin B12 and Vitamin B3 in a multidose vial, to meet the specific therapeutic needs of this individual patient. The inclusion of B12 and B3 is based on my clinical judgment of this patient's requirements. The multidose vial allows for flexible dose as needed to optimize treatment for this patient's unique condition. The pharmacy is directed to compound this preparation exclusively for the patient named in this prescription, with all dosing and administration to follow my specified instructions.

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's Name:	Supervising Physician (if applicable):
NPI/DEA:	Date/Time:
Prescriber's Signature	

Prescriber's name, address and phone number must be printed on all faxed prescriptions to be compliant with state law. Prescription must be signed by prescriber. By prescribing a compounded drug product the prescriber acknowledges that the compounded product will have a clinically significant effect for this individual patient.

**Fax form to Robins Pharmacy: 478-333-6228**