PHARMACY: _____

PHONE: _____

FAX: _____

Patient Name: _____

Date of Birth: ___/___/___ **Phone:** _____ **Allergies:** ☐ Yes _____ ☐ No

Address: _____

Deliver to: ☐ Patient Address or ☐ Clinic Address (patient request)

Bill to: ☐ Patient or ☐ Clinic

Semaglutide	
Semaglutide 4.36mg/ml + 5mg/ml Glycine #1ml (4.36mg)	☐
Semaglutide 4.36mg/ml + 5mg/ml Glycine #3ml (13.08mg)	☐

Tirzepatide	
Tirzepatide 11.25mg/ml + 5mg/ml Glycine #2ml (22.5mg)	☐
Tirzepatide 11.25mg/ml + 5mg/ml Glycine #3ml (33.75mg)	☐
Tirzepatide 22.5mg/ml + 5mg/ml Glycine #2.5ml (56.25mg)	☐
Tirzepatide 22.5mg/ml + 5mg/ml Glycine #4ml (90.00mg)	☐
Tirzepatide 22.5mg/ml + 5mg/ml Glycine #5ml (112.50mg)	☐

☐ Please provide a statement of significant difference documenting the medical need specific to this patient for the compounded product:

SIG:

Refills: _____

Prescriber: _____ **Phone:** _____

Address: _____

Signature: _____ **Date:** ___/___/___ **DEA:** _____

NPI: _____