NextRx

Prescription Form

Direct Phone: (573) 545-5278
Fax : (855) 710-6284
2909 Falling Leaf Lane
Columbia, MO 65201

SEMAGLUTIDE PRESCRIPTION ORDER FORM (2.5 mg/mL)

Patient Information			
Last Name:	First Name:		MI
Address:			Apt #
City:	State:	ZIP:	Phone #:
Date of Birth (mm/dd/yyyy)	Sex: M ☐ F ☐	Email:	

Prescriber Information			
Prescriber's Name:			
Phone #:	Fax #:		
Street Name:			
City:	State:	ZIP:	
NPI:	DEA:		

Compounded Semaglutide 2.5 mg/mL Injection Schedule

Mark intended starting dose below. Titration will then increase according to schedule.	Each dose is injected once a week for 4 weeks. After 4 weeks, you move up to the next dose. Each dose is to be injected in the subQ tissue of the abdomen within 2 inches of the navel. *vials expire 28 days after punctured.*		
0.25 mg	☐ 10 units (0.1 mL) weekly x 4 weeks	Quantity: 1 mL	Refills: _____
0.5 mg	☐ 20 units (0.2 mL) weekly x 4 weeks	Quantity: 1 mL	Refills: _____
1.0 mg	☐ 40 units (0.4 mL) weekly x 4 weeks	Quantity: 2 mL	Refills: _____
1.75 mg	☐ 70 units (0.7 mL) weekly x 4 weeks	Quantity: 4 mL	Refills: _____
2.5 mg	☐ 100 units (1 mL) weekly x 4 weeks	Quantity: 4 mL	Refills: _____

Other Instructions:

☐ **Zofran Prescription:** Ondansetron ODT 8mg 1t sublingual every 4 hours as needed Quantity: 30

☐ Include syringes, needles, and injection supplies (e.g., alcohol wipes).

_____
Date

X _____
Substitution Permitted

X _____
Dispense As Written