**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. | | |
|---|---|---|---|
| 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

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

______________________
Date

X ______________________
Substitution Permitted

X ______________________
Dispense As Written