Compounded GLP-1 Injection Order Form

Clinic Name: _____ Person Faxing: _____

Prescriber Name **(please print)**: _____ NPI: _____

Office Phone: _____ Office Fax: _____

Address: _____ City, State, Zip: _____

Prescriber Signature: _____ **Date:** _____

Patient Name: _____ **DOB:** _____

Patient Address: _____ City, State, Zip: _____

Patient Phone #: _____ Drug Allergies: _____

Email for Tracking Information (optional): _____

Select One: ☐ Ship/Deliver to Prescriber's Office Address ☐ Ship/Deliver to Patient's Home Address

Select One: ☐ Bill to Prescriber ☐ Bill to Patient

REQUIRED: Selection reason for non-essential copy. The dose and reason the FDA approved version is not appropriate for this patient will be screened by a pharmacist to ensure compliance with FDA regulations.
I, as the healthcare provider, attest to the following:

☐ My patient has an allergy to an ingredient in the commercial product
☐ My patient requires microdosing or altered titration due to medical need, clinic protocol, or to decrease side effects
☐ My patient receives a clinical difference with less side effects (nausea/vomiting) with leucine & pyridoxine at the time of admin
☐ My patient receives a clinical difference from vitamin B supplementation due to delayed gastric emptying, the potential impact of nutrient absorption, and/or the affect of vitamin B's role in energy metabolism, fatigue, weakness, and neuropathy

☐ Other: _____

Rx COMPOUNDED INJECTIONS: *(CDC & FDA recommend to discard multi-use vials 28 days after first puncture)*

☐ **Semaglutide / Leucine / Pyridoxine 5 / 10 / 10 mg / mL**

☐ **DISP: 1 mL vial**	Inject 8 units (**0.4 mg Semaglutide**) Sub-Q once weekly	
☐ **DISP: 1 mL vial**	Inject 16 units (**0.8 mg Semaglutide**) Sub-Q once weekly	
☐ **DISP: 1 mL vial**	Inject 24 units (**1.2 mg Semaglutide**) Sub-Q once weekly	
☐ **DISP: 2 - 1 mL vials**	Inject 30 units (**1.5 mg Semaglutide**) Sub-Q once weekly	
☐ **DISP: 2 - 1 mL vials**	Inject 24 units (**1.2 mg Semaglutide**) Sub-Q **twice** weekly	**(2.4mg/week)**
☐ **DISP: ____ 1 mL vial(s)**	Inject subcutaneously weekly as directed by provider	**(MAX: 4 VIALS)**
☐ **DISP: ____ 1 mL vial(s)**	_____	

☐ **Tirzepatide / Leucine / Pyridoxine 20 / 10 / 10 mg / mL**

☐ **DISP: 1 mL vial**	Inject 11 units (**2.2 mg Tirzepatide**) Sub-Q once weekly	
☐ **DISP: 1 mL vial**	Inject 15 units (**3 mg Tirzepatide**) Sub-Q once weekly	
☐ **DISP: 1 mL vial**	Inject 20 units (**4 mg Tirzepatide**) Sub-Q once weekly	
☐ **DISP: 2 - 1 mL vials**	Inject 30 units (**6 mg Tirzepatide**) Sub-Q once weekly	
☐ **DISP: 3 mL vial**	Inject 44 units (**8.8 mg Tirzepatide**) Sub-Q once weekly	
☐ **DISP: 3 mL vial**	Inject 56 units (**11.2 mg Tirzepatide**) Sub-Q once weekly	
☐ **DISP: 3 mL vial**	Inject 30 units (**6 mg Tirzepatide**) Sub-Q **twice** weekly	**(12 mg/week)**
☐ **DISP: ____ 1 mL vial(s)**	Inject subcutaneously weekly as directed by provider	**(MAX: 2 VIALS)**
☐ **DISP: ____ 1 mL vial(s)**	_____	
☐ **DISP: ____ 3 mL vial(s)**	Inject subcutaneously weekly as directed by provider	**(MAX: 2 VIALS)**
☐ **DISP: ____ 3 mL vial(s)**	_____	**Refills:** _____

SCAN FOR DOSING
FLOWCODE
PRIVACY.FLOWCODE.COM

☐ **Ondansetron 4mg ODT DISP: 10 tablets** Dissolve 1 tablet under the tongue every 6-8 hours as needed for nausea **Refills:** _____