INJECTABLE SEMAGLUTIDE ORDER FORM : COMPOUNDS

410-284-2424
410-284-0601 fax

PATIENT NAME: ______________________ DOB: __________ PHONE: __________

ADDRESS: ____

ALLERGIES: ____

SEMAGLUTIDE

Semaglutide 2.5mg/mL Injection Solution MDV (QTY #1 Month)

____ Inject 0.1 ML (0.25mg) subcutaneously once a week

____ Inject 0.2 ML (0.5mg) subcutaneously once a week

____ Inject 0.4 ML (1mg) subcutaneously once a week

____ Inject 0.5 ML (1.25mg) subcutaneously once a week

____ Inject 0.6 ML (1.5 mg) subcutaneously once a week

____ Inject 0.8 ML (2 mg) subcutaneously once a week

Custom Inject _____mg subcutaneously once a week

_____Refills

NAUSEA

☐ **Ondansetron 4mg ODT Tablets (QTY ☐ #10 ☐ #30)**
SIG: Place 1 tablet on the tongue, allow to dissolve then swallow
every 8 hours as needed for nausea.

PRESCRIBER NAME: ______________________ NPI: __________ DEA: __________

ADDRESS: ____

PHONE: __________ FAX: __________ CONTACT PERSON: __________

PRESCRIBER SIGNATURE: ______________________ DATE: __________

Please Fax Back to 410-284-0601