INJECTABLE TIRZEPATIDE RX ORDER FORM: COMPOUNDS

Drug City Pharmacy
2805 North Point Rd
Baltimore, MD 21222

PATIENT NAME: _____ DOB: _____ PHONE: _____

ADDRESS: _____

ALLERGIES: _____

Please complete the above demographics or send in a face sheet.

TIRZEPATIDE

☐ **Tirzepatide 10mg/mL Injection Solution MDV (QTY #2mL)**
SIG: Inject 2.5mg subcutaneously once a week for 4 weeks.

☐ **Tirzepatide 10mg/mL Injection Solution MDV (QTY #2mL)**
SIG: Inject 5mg subcutaneously once a week for 4 weeks.

☐ **Tirzepatide 20mg/mL Injection Solution MDV (QTY #2mL)**
SIG: Inject 7.5mg subcutaneously once a week for 4 weeks.

☐ **Tirzepatide 20mg/mL Injection Solution MDV (QTY #2mL)**
SIG: Inject 10mg subcutaneously once a week for 4 weeks.

CUSTOM TIRZEPATIDE

☐ **Tirzepatide Injection Solution MDV** ☐ **#2mL** ☐ **#4mL)**
SIG: Inject _____mg subcutaneously ____time(s) a week for ____weeks.

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: _____ REFILLS: _____

Please Fax Back to 410-284-0601