SEMAGLUTIDE

Clinic Name	
Address	
Phone	

Prescriber		NPI/DEA	

☐ New Patient (if new, please include address and phone number with DOB)
☐ Existing Patient (if existing, only DOB required unless information changed)

Patient Name		DOB	

Patient Address	
Patient Phone	
Patient Email	(Optional for shipping)

Allergy: _____

☐ Ship to Clinic	☐ Ship to Patient	☐ Patient/Clinic Pick-up	☐ Bill Patient	☐ Bill Clinic

Compound	Size
☐ ***SEMAGLUTIDE, 1.2mg/mL INJECTION***	6mL (4-VIAL PACK)
☐ ***SEMAGLUTIDE, 1.2mg/mL INJECTION***	1.5mL VIAL

☐ Include syringes (extra fee)
☐ Permissible to compound due to intolerance to commercially available product
☐ Permissible to compound due to sensitivity to inactive ingredients in commercial product

Directions: _____Qty: _____ Refills:_____

Authorized Person: _____Date: _____

Signature:_____

PRINT **CLEAR**