

PATIENT NAME: _____ DOB: _____ PHONE: _____

ADDRESS: _____

ALLERGIES: _____

Tirzepatide

 Tirzepatide/Vitamin B6 Injection Solution **10 mg/10mg vial** **30 mg/30mg vial** **60 mg/30mg vial** Inject 2.5 mg subcutaneously once a week Inject 5 mg subcutaneously once a week Inject 7.5 mg subcutaneously once a week Inject 10 mg subcutaneously once a week Inject 12.5 mg subcutaneously once a week Inject 15 mg subcutaneously once a week

_____ Refills

Semaglutide

 Semaglutide/Vitamin B3/Vitamin B12 2.5-2-0.5 mg/mL (MDV) Inject 10 units (0.25 MG) subcutaneously once a week Inject 20 units (0.5 MG) subcutaneously once a week Inject 40 units (1 MG) subcutaneously once a week Inject 60 units (1.5 MG) subcutaneously once a week Inject 80 units (2 MG) subcutaneously once a week Inject 100 units (2.5 MG) subcutaneously once a week

_____ Refills

Nausea

 Ondansetron 4 mg 8 mg. #30 _____ Refills

SIG: Take 1-2 tablets by mouth every 6-8 hours as needed for nausea

PRESCRIBER NAME: _____ NPI: _____ DEA: _____

ADDRESS: _____

PHONE: _____ FAX: _____ SUPERVISING: _____

PRESCRIBER SIGNATURE: _____ DATE: _____

I certify that I have determined this compounded preparation is medically necessary for this individually identified patient and that no commercially available product adequately meets the patient's specific medical needs.