Allcare
PHARMACY & COMPOUNDING

# GLP-1

112 S OXLEY DR. LYONS, GA
Ph#: 912-526-3206
Fax#: 912-526-5960

PATIENT NAME: _____ DOB: _____ PHONE: _____

ADDRESS: _____

ALLERGIES: _____

## Tirzepatide

☐ **Tirzepatide/B3/B12**

- ☐ Inject 2.5 mg subcutaneously once a week
- ☐ Inject 5 mg subcutaneously once a week
- ☐ Inject 7.5 mg subcutaneously once a week

_____Refills

## HIGH DOSE- Tirzepatide

☐ **Tirzepatide**

- ☐ 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
- ☐ Inject _____ mg subcutaneously once a week

_____Refills

**Pick your additive!**

- ☐ B-12
- ☐ Glycine
- ☐ L-Carnitine

★ If an additive is not selected it will be defaulted to B-12.

## 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

**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.