

Weight-Loss Protocol
Order Form

AREA RESERVED FOR PHARMACY



Prescriber Information		
Practice Name		
Street Address		
City	State	ZIP
Phone	Fax	

Patient Information		
Name		DOB
Street Address		Phone
City	State	ZIP
Sex	Allergies	

Pharmacy To Dispense			
Semaglutide-Niacinamide-Cyanocobalamin 2.5-2-0.5 mg/mL (MDV) (please choose Sig:)			
<input type="checkbox"/>	Inject 10 UNITS (0.25 mg) SQ once a week for 4 weeks and titrate UD		
<input type="checkbox"/>	Inject 20 UNITS (0.5 mg) SQ once a week for 4 weeks and titrate UD		
<input type="checkbox"/>	Inject 40 UNITS (1 mg) SQ once a week for 4 weeks and titrate UD		
<input type="checkbox"/>	Inject 60 UNITS (1.5 mg) SQ once a week for 4 weeks and titrate UD		
<input type="checkbox"/>	Inject 80 UNITS (2 mg) SQ once a week for 4 weeks and titrate UD		
<input type="checkbox"/>	Inject 100 UNITS (2.5 mg) SQ once a week for 4 weeks and titrate UD		
<input type="checkbox"/>	Inject _____ UNITS SQ once a week for 4 weeks and titrate UD		
Quantity	<input type="checkbox"/> 1 month	Other: _____ (60 day max)	# of refills: _____
Tirzepatide-Niacinamide-Cyanocobalamin 10-2-0.5 mg/mL (MDV) (please choose Sig:)			
<input type="checkbox"/>	Inject 25 UNITS (2.5 mg) SQ once a week for 4 weeks and titrate UD		
<input type="checkbox"/>	Inject 50 UNITS (5 mg) SQ once a week for 4 weeks and titrate UD		
<input type="checkbox"/>	Inject 75 UNITS (7.5 mg) SQ once a week for 4 weeks and titrate UD		
<input type="checkbox"/>	Inject 100 UNITS (10 mg) SQ once a week for 4 weeks and titrate UD		
<input type="checkbox"/>	Inject 125 UNITS (12.5 mg) SQ once a week for 4 weeks and titrate UD		
<input type="checkbox"/>	Inject 150 UNITS (15 mg) SQ once a week for 4 weeks and titrate UD		
<input type="checkbox"/>	Inject _____ UNITS SQ once a week for 4 weeks and titrate UD		
Quantity	<input type="checkbox"/> 1 month	Other: _____ (60 day max)	# of refills: _____

Pharmacy Reference	
Prescriber does not need to fill out this section.	
SemaPlus (max 10mL)	
Units/Week	Vial Size
10-25	1mL
26-50	2mL
51-75	3mL
76-100	2mL + 2mL
100+	3mL + 2mL
TirzPlus (max 12mL)	
Units/Week	Vial Size
10-25	1mL
26-50	2mL
51-75	3mL
76-100	2mL + 2mL
101-125	2mL + 3mL
126+	3mL + 3mL
Vials expire 28 days after first puncture by patient. Pharmacy to dispense appropriate volume and quantity of U-100 syringes/needles.	

Prescriber Section		
<p>This formulation combines a GLP-1 receptor agonist with Vitamin B12 and Vitamin B3 in a multidose vial, to meet the specific therapeutic needs of this individual patient. The inclusion of B12 and B3 is based on my clinical judgment of this patient's requirements. The multidose vial allows for flexible dose titration in both directions—either increasing or decreasing the dose as needed—to optimize treatment for this patient's unique condition. The pharmacy is directed to compound this preparation exclusively for the patient named in this prescription, with all dosing and administration to follow my specified instructions.</p> <p>I certify that the above patient does not have a family/personal history of Medullary Thyroid Cancer or a personal history of Multiple Endocrine Neoplasia.</p>		
Prescriber	Physician	NPI
Prescriber Signature		Date/Time

Send the completed form to Allcare Pharmacy & Compounding

Fax: 912-526-6830