

**INJECTABLE SEMAGLUTIDE  
RX ORDER FORM : COMPOUNDS**



Fax to: \_\_\_\_\_  
Email to: \_\_\_\_\_  
or call \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ PHONE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
ALLERGIES: \_\_\_\_\_  
Please complete the above demographics or send in a face sheet.

**SEMAGLUTIDE**

- Semaglutide 2.5mg/mL Injection Solution MDV (QTY #2mL)**  
SIG: Inject 10 units (0.25mg) subcutaneously once a week for 4 weeks.
- Semaglutide 2.5mg/mL Injection Solution MDV (QTY #2mL)**  
SIG: Inject 20 units (0.5mg) subcutaneously once a week for 4 weeks.
- Semaglutide 2.5mg/mL Injection Solution MDV (QTY #2mL)**  
SIG: Inject 40 units (1mg) subcutaneously once a week for 4 weeks.

**CUSTOM SEMAGLUTIDE**

- Semaglutide 2.5mg/mL Injection Solution MDV (QTY #2mL)**  
SIG: Inject \_\_\_\_\_ mg subcutaneously \_\_\_\_\_ time(s) a week for \_\_\_\_\_ weeks.

PRESCRIBER NAME: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ CONTACT PERSON: \_\_\_\_\_  
PRESCRIBER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_ REFILLS: \_\_\_\_\_

\*The FDA does not assess the safety or effectiveness of compounded medications.