INJECTABLE SEMAGLUTIDE RX ORDER FORM : COMPOUNDS

Fax to: _____

Email to: _____

or call _____

Kaitlyn's Pharmacy
Drugs At Lower Prices

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 (QTL #3mL)**

SIG: Inject 10 units (0.25mg) subcutaneously once a week for 4 weeks.

☐ **Semaglutide 2.5mg/mL Injection Solution MDV (QTL #3mL)**

SIG: Inject 20 units (0.5mg) subcutaneously once a week for 4 weeks.

☐ **Semaglutide 2.5mg/mL Injection Solution MDV (QTL #3mL)**

SIG: Inject 40 units (1mg) subcutaneously once a week for 4 weeks.

CUSTOM SEMAGLUTIDE

☐ **Semaglutide 2.5mg/mL Injection Solution MDV (QTL #3mL)**

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.

9100-A S.Tryon St. Charlotte, NC 28273
(704) 588-9623 • kaitlynspharmacy@gmail.com