Weight-Loss Protocol
Order Form

AREA RESERVED FOR PHARMACY

Hogan's PHARMACY · EST. 1976

Prescriber Information

Practice Name		
Street Address		
City	State	ZIP
Phone	Fax	

Patient Information

Name		DOB
Street Address		
City	State	ZIP
Phone	Email	
Allergies	Sex	

Pharmacy To Dispense

Semaglutide 2.5mg/mL (please choose Sig:)

- ☐ Inject 10 UNITS (0.25 mg) subcutaneously once a week for 4 weeks
- ☐ Inject 20 UNITS (0.5 mg) subcutaneously once a week for 4 weeks
- ☐ Inject 40 UNITS (1 mg) subcutaneously once a week for 4 weeks
- ☐ Inject 60 UNITS (1.5 mg) subcutaneously once a week for 4 weeks
- ☐ Inject 80 UNITS (2 mg) subcutaneously once a week for 4 weeks
- ☐ Inject 100 UNITS (2.5 mg) subcutaneously once a week for 4 weeks
- ☐ Inject _____ UNITS subcutaneously once a week for 4 weeks

Quantity ☐ 1 month   Other:_____ (60 day max)   # of refills:____

Tirzepatide 5mg/0.5mL (please choose Sig:)

- ☐ Inject 25 UNITS (2.5 mg) subcutaneously once a week for 4 weeks
- ☐ Inject 50 UNITS (5 mg) subcutaneously once a week for 4 weeks
- ☐ Inject 75 UNITS (7.5 mg) subcutaneously once a week for 4 weeks
- ☐ Inject 100 UNITS (10 mg) subcutaneously once a week for 4 weeks
- ☐ Inject 125 UNITS (12.5 mg) subcutaneously once a week for 4 weeks
- ☐ Inject 150 UNITS (15 mg) subcutaneously once a week for 4 weeks
- ☐ Inject _____ UNITS subcutaneously once a week for 4 weeks

Quantity ☐ 1 month   Other:_____ (60 day max)   # of refills:____

Pharmacy Reference

Prescriber does not need to fill out this section. Dispense up to 60/day supply.

Semaglutide (max 10mL)	
Units/Week	Vial Size
10-25	1mL
26-50	2mL
51-75	3mL
76-100	2mL + 2mL
100+	3mL + 2mL

Tirzepatide (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

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.

Prescriber Name	Supervising Physician	NPI
Prescriber Signature		Date/Time

Send the completed form to Hogan's Pharmacy
Fax: 229-244-5357