Tirzepatide Injectable
ORDER FORM

Patient's Name:	Prescriber's Name:
Street Address:	Street Address:
City, State ZIP:	City, State ZIP:
Date of Birth:	Office #:
Phone #:	Fax #:
Additional Contact #:	Patient Allergies:

PRESCRIBER'S SIGNATURE: **X** ____**DATE:**________________

COMPOUNDED TIRZEPATIDE

____ 2.5mg (10mg/ml) Inject 0.25ml SQ once weekly for 4 weeks. 1ml vial
____ 5mg (10mg/ml) Inject 0.5ml SQ once weekly for 4 weeks. 2ml vial
____ 7.5mg (15mg/ml) Inject 0.5ml SQ once weekly for 4 weeks. 2ml vial
____ 10mg (20mg/ml) Inject 0.5ml SQ once weekly for 4 weeks. 1ml x2 vials
____ 12.5mg (20mg/ml) Inject 0.625ml once weekly for 4 weeks. 3ml vial
____ 15mg (20mg/ml) Inject 0.75ml once weekly for 4 weeks. 3ml vial

- If you would like patient to use step therapy until 15mg weekly dose is reached, please initial here: _________ *Patient will increase dosage monthly until 15mg is reached.

- Refills _____

FDA does not review compounded medication for safety or efficacy.
Manufactured by GreenstoneRx.

*05/11/2026