Tirzepatide/Vitamin B6 Injectable
20mg/10mg/ml 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/VITAMIN B6

I. ____ Tirzepatide/Vitamin B6 Injectable 20mg/10mg/ml

i. ____ **Initial Dose**: Inject 0.125ml (2.5mg) SQ once weekly for 4 weeks.
ii. ____ Inject 0.25ml (5mg) SQ once weekly for 4 weeks.
iii. ____ Inject 0.375ml (7.5mg) SQ once weekly for 4 weeks.
iv. ____ Inject 0.5ml (10mg) SQ once weekly for 4 weeks.
v. ____ Inject 0.625ml (12.5mg) once weekly for 4 weeks.
vi. ____ Inject 0.75ml (15mg) once weekly for 4 weeks.

- Vitamin B6 added to reduce nausea, vomiting, and fatigue Prescriber Initials required: _____

- If you would like patient to use step therapy until 1.0ml weekly dose is reached, please initial here: _____ *Patient will increase dosage monthly until 1.0ml is reached.

- Refills ____

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

*12.29.2025