GLP-1 INJECTABLE RX ORDER FORM

S&J Argyle Pharmacy
101 Old Town Blvd. S. #102
Argyle, TX 76226
PH: 940-464-4500
FAX: 940-464-4533

Patient Name: _____ Phone Number: _____

Date of Birth: _____ Allergies: _____

Address: _____

City: _____ State: _____ ZIP: _____

Semaglutide Options 1mg/mL

☐ **Glycine 5mg/Semaglutide 1mg/mL Injections**
QTY: ___ 2mL $168 ___4mL (2x2mL) $258 ___ 5mL $268

SIG: Inject subcutaneously once weekly
___0.25mg (0.25mL = 25 syringe units)
___0.5mg (0.5mL = 50 syringe units)
___1mg (1mL = 100 syringe units)
___Other _____

Semaglutide Options 2.4mg/mL

☐ **Glycine 5mg/Semaglutide 2.4mg/mL Injections**
QTY: ___ 2mL $198 ___4mL (2x2mL) $298 ___ 5mL $308

SIG: Inject subcutaneously once weekly
___1.2mg (0.5mL = 50 syringe units)
___1.68mg (0.7mL = 70 syringe units)
___2.4mg (1mL = 100 syringe units)
___Other _____

Tirzepatide Options 12.5mg/mL

☐ **Hydroxocobalamin 2.5mg/Tirzepatide 12.5mg/mL Injections**
QTY: ___ 2mL $198 ___4mL (2x2mL) $298

☐ **Glycine 5mg/ Tirzepatide 12.5mg/mL Injections**
QTY: ___2mL $198 ___ 4mL (2x2mL) $298

SIG: Inject subcutaneously once weekly
___2.5mg (0.2mL = 20 syringe units)
___5mg (0.4mL = 40 syringe units)
___Other _____

Tirzepatide Options 25mg/mL

☐ **Hydroxocobalamin 2.5mg/Tirzepatide 25mg/mL Injections**
QTY: ___ 2mL $268 ___4mL (2x2mL) $428

☐ **Glycine 5mg/ Tirzepatide 25mg/mL Injections**
QTY: ___ 2mL $268 ___4mL (2x2mL) $428 ___6mL (3x2mL) $528

SIG: Inject subcutaneously once weekly
___7.5mg (0.3mL = 30 syringe units)
___10mg (0.4mL = 40 syringe units)
___12.5mg (0.5mL = 50 syringe units)
___15mg (0.6mL = 60 syringe units)
___Other _____

REFILLS: _____ *Please note that each 2mL / 5mL vial has a beyond-use date of 60 days.*

MEDICAL RATIONALE REQUIRED (CHECK ONE)

☐ Patient requires additional drug component(s) to decrease risk of side effects or due to an underlying medical condition.
☐ Patient has a sensitivity, allergy, or intolerance to an ingredient in the commercially available product and/or requires avoidance.
☐ Patient requires a dose and/or route of administration that is unachievable with the commercially available product.

Please note that a medical rationale is required for all compounded medications by law. Compounded prescriptions without a medical rationale or with a rationale related to finances/insurance coverage cannot be filled and will be rejected by the pharmacy.

PRESCRIBER NAME: _____ NPI: _____ DEA: _____

ADDRESS: _____

PHONE: _____ FAX: _____ CONTACT PERSON: _____

PRESCRIBER SIGNATURE: _____ DATE: _____