

# WEIGHT MANAGEMENT PRESCRIPTION FORM

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

**Owl Specialty Pharmacy**  
 1010 E. Arrow Hwy., Covina, CA 91724  
 Phone: 626-209-8169 Fax: 626-209-8171 or 855-817-9523  
[www.owlspecialty.com](http://www.owlspecialty.com)



Patient Information: please provide a copy of the patient's insurance card or information				
Patient Name:		DOB:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M	HT:
Address:		City:	State:	Phone:
Insurance:	Subscriber's name:	ID#:	Group #:	
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> List allergies:				
Clinical Information: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization				
Diagnosis / ICD-10:				
Prior Therapies:				
Prescription Information				
Medication	Dose / Strength	Directions	Quantity	Refills
<input type="checkbox"/> Saxenda	<input type="checkbox"/> 18 Mg/3 MI Pen w/ 5 mm pentips	<input type="checkbox"/> Week [1]: inject 0.6mg SC once daily for [7] days <input type="checkbox"/> Week [2]: inject 1.2mg SC once daily for [7] days <input type="checkbox"/> Week [3]: inject 1.8mg SC once daily for [7] days <input type="checkbox"/> Week [4]: inject 2.4 mg SC once daily for [7] days <input type="checkbox"/> Week [5]: and thereafter : inject 3mg SC once daily <input type="checkbox"/> Inject 3mg SC once daily		
<input type="checkbox"/> Victoza	<input type="checkbox"/> 2-Pak 18 Mg/3 MI Pen w/ 5 mm pentips <input type="checkbox"/> 3-Pak 18 Mg/3 MI Pen w/ 5 mm pentips	<input type="checkbox"/> INJECT 1.2MG SC ONCE DAILY <input type="checkbox"/> INJECT 1.8MG SC ONCE DAILY <input type="checkbox"/> Week [1]: inject 0.6 mg daily for [7] days <input type="checkbox"/> Week [2]: and thereafter : inject 1.2 mg SC once daily		
<input type="checkbox"/> Wegovy	<input type="checkbox"/> 0.25 mg/0.5 mL pen <input type="checkbox"/> 0.5 mg/0.5 mL pen <input type="checkbox"/> 1 mg/0.75 mL pen <input type="checkbox"/> 1.7 mg/0.75 mL pen <input type="checkbox"/> 2.4 mg/0.75 mL pen	<input type="checkbox"/> Inject 0.25 mg SC every week for 4 weeks, then; <input type="checkbox"/> Inject 0.5 mg SC every week for 4 weeks, then; <input type="checkbox"/> Inject 1 mg SC every week for 4 weeks, then; <input type="checkbox"/> Inject 1.7 mg SC every week for 4 weeks, then; <input type="checkbox"/> Inject 2.4 mg SC every week.	<input type="checkbox"/> 4 week supply	
Prescriber Information				
Prescriber name:		Phone:	Office contact name:	
Prescriber address:		City:	State:	Zip:
NPI:	DEA:	Fax and/or Email:		
Prescriber signature:		Date:	<input type="checkbox"/> DO NOT SUBSTITUTE	

**Important Notice:** This facsimile transmission is intended to be delivered only to the named recipient(s), and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named recipient, immediately notify the sender at the address and phone number set forth herein and obtain instructions as to properly dispose of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except authority of the sender to the named addressee.