Fax to: (330) 931-4460

# Prescription Compound Facsimile Transmission Form

Klein's custom compounding

*Please Attach Patient **Demographics sheet** and/or **Prescription Insurance Card**

**Rep Name:_____ Phone:_____**

| **Physician Name:** | | |
|---|---|---|
| Address: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | |
| NPI: | DEA: | |

| **Patient Name:** | | **D.O.B** |
|---|---|---|
| Allergies | | |
| Home Phone | Mobile | |
| Address | | |
| City | State | Zip Code |

## Semaglutide Premium Starter Package ($350.00)

☐ **Semaglutide 2mg/ml**

*Sig:* Once daily, place 0.25ml under tongue for a minimum of 60 seconds (ideally as long as possible) then swallow. Follow titration schedule until taking every day with little to no side effects. Do not eat for 30 minutes after taking.

Includes:

- ☐ Compounded Semaglutide
- ☐ Core Restore (Van or Choc) – 7 day detox to be taken prior to Semaglutide
- ☐ Active Life – Multivitamin
- ☐ Men's Probiotic Complete – improve GI Health
- ☐ Crave Control – Helps suppress food cravings
- ☐ Docusate Sodium – Stool Softener

## Semaglutide Basic Starter Package ($250.00)

☐ **Semaglutide 2mg/ml**

*Sig:* Once daily, place 0.25ml under tongue for a minimum of 60 seconds (ideally as long as possible) then swallow. Follow titration schedule until taking every day with little to no side effects. Do not eat for 30 minutes after taking.

Includes:

- ☐ Compounded Semaglutide
- ☐ Active Life – Multivitamin
- ☐ Crave Control – Helps suppress food cravings
- ☐ Docusate Sodium – Stool Softener

## Semaglutide Maintenance Package ($150.00)

☐ **Semaglutide 2mg/ml**

☐ **Semaglutide 4mg/ml**

*Sig:* Once daily, place 0.25ml under tongue for a minimum of 60 seconds (ideally as long as possible) then swallow. Do not eat for 30 minutes after taking.

Includes:

- ☐ Compounded Semaglutide
- ☐ Active Life – Multivitamin

Can be added for additional cost if needed

- ☐ Crave Control – Helps suppress food cravings
- ☐ Docusate Sodium – Stool Softener

## Starter Package Titration Schedule

Month #1 Instructions 2mg/ml

| | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
|---|---|---|---|---|---|---|---|
| Week 1 | 0.25 ML | | | 0.25 ML | | | 0.25 ML |
| Week 2 | | 0.25 ML | | 0.25 ML | | 0.25 ML | |
| Week 3 | 0.25 ML | 0.25 ML | 0.25 ML | 0.25 ML | 0.25 ML | 0.25 ML | 0.25 ML |
| Week 4 | 0.25 ML | 0.25 ML | 0.25 ML | 0.25 ML | 0.25 ML | 0.25 ML | 0.25 ML |

Refills: **0 1 2 3 Or** _____ Compound Quantity ☐ **4mL Or** _____

Provider Signature: Date:

Signing this prescription, I certify that the prescription written by me is based on a valid patient/provider relationship within the normal course of my practice. I will comply with State and Federal laws by retaining a copy of prescription.

*The compounds and other medications listed on this prescription are available by prescription only. The FDA does not approve these to cure, treat, or mitigate disease. The formulations and medications listed represent commonly prescribed formulas for the disease states indicated. This is not intended to advertise claims of efficacy for individualized formulations.*

2015 State Road | Suite A Cuyahoga Falls, OH 44223 www.kleinspharmacy.com PHONE (330) 929-9183

# Patient Information Handout

Your physician has prescribed you a medication at your visit today that requires specialty compounding. At **Klein's Pharmacy**, we specialize in dispensing specialty compounded prescriptions.

**Klein's Pharmacy** will work with *you*, your prescriber, and insurance company to get your medication covered at the lowest possible cost (co-pay). Unless your co-pay is $0.00 Klein's Pharmacy will not be able to ship your medication until we get your approval.

Expect a member from **Klein's Pharmacy** team to reach out to you. If you do not hear from us within 48 hours, please call us at **(330)-929-9183 x4**. Calling in advance will allow us to verify your information and process your prescription in a more timely manner. Your prescription will be mailed to your home via USPS at no charge to you! You can also pick up your medication at our convenient Cuyahoga Falls location. Total processing time is usually between 3-5 business days.

## Automatic Refill Authorization

If you would like for us to **automatically** refill your prescription *without* having to call you each time it is due to be filled please print and sign below.

*Name: First*_____
*Last*_____

*Signature*_____
*Date*_____

Please do not hesitate to call us with ANY questions, comments, or concerns at **(330)-929-9183 x4**. A team member is available Monday-Friday from 9am- 5pm.