

Weight-Loss Protocol
Order Form

AREA RESERVED FOR PHARMACY



Prescriber Information		
Practice Name		
Street Address		
City	State	ZIP
Phone	Fax	

Patient Information		
Name		DOB
Street Address		
City	State	ZIP
Phone	Email	
Allergies	Sex	

Pharmacy To Dispense			
Semaglutide 2.5mg/mL (please choose Sig:)			
<input type="checkbox"/>	Inject 10 UNITS (0.25 mg) subcutaneously once a week for 4 weeks		
<input type="checkbox"/>	Inject 20 UNITS (0.5 mg) subcutaneously once a week for 4 weeks		
<input type="checkbox"/>	Inject 40 UNITS (1 mg) subcutaneously once a week for 4 weeks		
<input type="checkbox"/>	Inject 60 UNITS (1.5 mg) subcutaneously once a week for 4 weeks		
<input type="checkbox"/>	Inject 80 UNITS (2 mg) subcutaneously once a week for 4 weeks		
<input type="checkbox"/>	Inject 100 UNITS (2.5 mg) subcutaneously once a week for 4 weeks		
<input type="checkbox"/>	Inject _____ UNITS subcutaneously once a week for 4 weeks		
Quantity	<input type="checkbox"/> 1 month	Other: _____ (60 day max)	# of refills: _____
Tirzepatide 5mg/0.5mL (please choose Sig:)			
<input type="checkbox"/>	Inject 25 UNITS (2.5 mg) subcutaneously once a week for 4 weeks		
<input type="checkbox"/>	Inject 50 UNITS (5 mg) subcutaneously once a week for 4 weeks		
<input type="checkbox"/>	Inject 75 UNITS (7.5 mg) subcutaneously once a week for 4 weeks		
<input type="checkbox"/>	Inject 100 UNITS (10 mg) subcutaneously once a week for 4 weeks		
<input type="checkbox"/>	Inject 125 UNITS (12.5 mg) subcutaneously once a week for 4 weeks		
<input type="checkbox"/>	Inject 150 UNITS (15 mg) subcutaneously once a week for 4 weeks		
<input type="checkbox"/>	Inject _____ UNITS subcutaneously once a week for 4 weeks		
Quantity	<input type="checkbox"/> 1 month	Other: _____ (60 day max)	# of refills: _____

Pharmacy Reference	
Prescriber does not need to fill out this section. Dispense up to 60/day supply.	
Semaglutide (max 10mL)	
Units/Week	Vial Size
10-25	1mL
26-50	2mL
51-75	3mL
76-100	2mL + 2mL
100+	3mL + 2mL
Tirzepatide (max 12mL)	
Units/Week	Vial Size
10-25	1mL
26-50	2mL
51-75	3mL
76-100	2mL + 2mL
101-125	2mL + 3mL
126+	3mL + 3mL
Vials expire 28 days after first puncture by patient. Pharmacy to dispense appropriate volume and quantity of U-100 syringes/needles.	

Prescriber Section		
I certify that the above patient does not have a family/personal history of Medullary Thyroid Cancer or a personal history of Multiple Endocrine Neoplasia.		
Prescriber Name	Supervising Physician	NPI
Prescriber Signature		Date/Time

Send the completed form to Bethelview Pharmacy
Fax: 470-253-4894