BETHELVIEW PHARMACY
2336 Atlanta Hwy | Cumming, GA 30040
P: 470-253-4893
F: 470-253-4894

Weight-Loss Order Form

Provider Information:

OFFICE NAME:	
OFFICE ADDRESS:	
OFFICE PHONE:	OFFICE FAX:

Patient Information:

NAME:	DOB:	Sex:
ADDRESS:		
PHONE:	Allergies:	

Semaglutide - Niacinamide-Cyanocobalamin 2.5-2-0.5 mg/ml (MDV) Please select Sig:

	Inject 10 units (0.25mg) SQ weekly x 4 weeks (QTY: 1ml)
	Inject 20 units (0.5mg) SQ weekly x 4 weeks (QTY: 1ml)
	Inject 40 units (1mg) SQ weekly x 4 weeks (QTY: 2ml)
	Inject 60 units (1.5mg) SQ weekly x 4 weeks (QTY: 3ml)
	Inject 80 units (2mg) SQ weekly x 4 weeks (QTY: 3.5ml)
	Inject 100 units (2.5mg) SQ weekly x 4 weeks (QTY: 4ml)

Quantity:_____

Refills:_____

***Administration supplies included**

Tirzepatide - Niacinamide-Cyanocobalamin 10-2-0.5 mg/ml (MDV) Please select Sig:

	Inject 25 units (2.5mg) SQ weekly x 4 weeks (QTY: 1ml)
	Inject 50 units (5mg) SQ weekly x 4 weeks (QTY: 2ml)
	Inject 75 units (7.5mg) SQ weekly x 4 weeks (QTY: 3ml)
	Inject 100 units (10mg) SQ weekly x 4 weeks (QTY: 4ml)
	Inject 125 units (12.5mg) SQ weekly x 4 weeks (QTY: 5ml)
	Inject 150 units (15mg) SQ weekly x 4 weeks (QTY: 6ml)

Quantity:_____

Refills:_____

***Administration supplies included**

Vials expire 28 days after first puncture by patient. Pharmacy to dispense appropriate volume and quantity of U-100 syringes/needles.

This formulation combines a GLP-1 receptor agonist with Vitamin B12 and Vitamin B3 in a multidose vial, to meet the specific therapeutic needs of this individual patient. The inclusion of B12 and B13 is based on my clinical judgment of this patient's requirements. The multidose vial allows for flexible dose titration in both directions—either increasing or decreasing the dose as needed—to optimize treatment for this patient's unique condition. The pharmacy is directed to compound this preparation exclusively for the patient named in this prescription, with all dosing and administration to follow my specified instructions. 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's Name: _____ NPI: _____

Prescriber's Signature: _____ Date: _____

Supervising Physician *(if applicable)*: _____

SEND COMPLETED FORM TO: BETHELVIEW PHARMACY
FAX: 470-253-4894 | E-SCRIBE NCPDP#: 1180455