COMPOUNDED PRESCRIPTION ORDER

DATE: _____

PRESCRIBER INFORMATION		
Practice Name		
Street Address		
City	State	Zip
Phone	Fax	

PATIENT INFORMATION		
Name		DOB
Street Address		
City	State	Zip
Phone	Email	
Allergies		

PHARMACY TO DISPENSE: TIRZEPATIDE 5 MG/ 0.5 ML INJECTION

Please choose Sig:	
▢	Inject 25 UNITS (2.5 mg) subcutaneously once a week for 4 weeks
▢	Inject 50 UNITS (5 mg) subcutaneously once a week for 4 weeks
▢	Inject 75 UNITS (7.5 mg) subcutaneously once a week for 4 weeks
▢	Inject 100 UNITS (10 mg) subcutaneously once a week for 4 weeks
▢	Inject 125 UNITS (12.5 mg) subcutaneously once a week for 4 weeks
▢	Inject 150 UNITS (15 mg) subcutaneously once a week for 4 weeks
▢	Inject _____ UNITS subcutaneously once a week for 4 weeks

Pharmacy to dispense appropriate volume and quantity of U-100 syringes/needles

DISPENSE: 1 MONTH SUPPLY **Refills: _____**

This table is for pharmacist reference.
Prescriber does not need to fill out this section.

UNITS PER WEEK	VIAL SIZE TO DISPENSE
10 - 25	1 mL ($199)
26 - 50	2 mL ($299)
51 - 75	3 mL ($379)
76-100	2 x 2 mL ($459)
101-125	5 mL ($549)
126-150	2 x 3 mL ($619)

Vial expires 28 days after first puncture by patient

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	
Prescriber Signature	Date/Time

Form provided by Robins Pharmacy fax to 478-333-6228