MOUNTAIN CARE PHARMACY

SEMAGLUTIDE COMBINATION PEN INJECTOR FORM

PLEASE FAX ORDER TO (208) 287-4668

****COMPOUNDING FOR MEDICAL NECESSITY****

PATIENT INFORMATION:

PATIENT NAME: _____ DOB: _____

PHONE: _____ ADDRESS: _____

ALLERGIES: _____ EMAIL: (REQUIRED) _____

SEMAGLUTIDE COMBINATION PEN INJECTION PRODUCTS

CHECK ONE:

COMPOUND NAME	STRENGTH/ML	SPECIAL INDICATION / OTHER INDICATION
☐ SEMAGLUTIDE / CYANOCOBALAMIN	5/6.25MG	SPECIAL INDICATION: BOOST METABOLISM AND ENERGY OR OTHER INDICATION:_____
☐ SEMAGLUTIDE / PYRIDOXINE	5/5MG	SPECIAL INDICATION: NAUSEA OR OTHER INDICATION:_____
☐ SEMAGLUTIDE / GLYCINE	5/15MG	SPECIAL INDICATION: TISSUE REGENERATION, MUSCLE RECOVERY/ENERGY, AND IMPROVED COGNITIVE FUNCTION OR OTHER INDICATION:_____
☐ SEMAGLUTIDE / CHOLINE	5/30MG	SPECIAL INDICATION: BOOST FAT METABOLISM OR OTHER INDICATION:_____

CHECK ONE: PEN INJECTION DIRECTIONS:

SEMAGLUTIDE COMBO DIRECTIONS

☐ Inject 0.25mg subcutaneously once weekly for weeks 1 through 4 then titrate to effect by 0.25mg every 4 weeks to a max dose of 2mg subcutaneously once weekly.

☐ Fulfill order with pen injector at _____ dose.

☐ Alternate Titration: _____

_____

_____

_____

SEMAGLUTIDE COMBO PEN INJECTOR COST:

☐ $120.00 PER 1.0ML PEN (FOR DOSES 0.25MG - 1.25MG)

☐ $180.00 PER 2.0ML PEN (FOR DOSES 1.5MG - 2.5MG)

 # OF REFILLS: _____

OR

 # OF MONTHS RE-FILLABLE: _____

PLEASE INDICATE (CIRCLE ONE OF EACH BILL AND DELIVER):

☐ BILL PROVIDER OR BILL PATIENT ☐

☐ DELIVER TO PROVIDER OR DELIVER TO PATIENT ☐

PRESCRIBER INFORMATION:

CLINIC NAME: _____ PRESCRIBER NAME: _____

PHONE: _____ ADDRESS: _____

FAX: _____ DEA: _____ NPI: _____

PRESCRIBER SIGNATURE: _____ DATE: _____