MOUNTAIN CARE PHARMACY

TIRZEPATIDE 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) _____

TIRZEPATIDE COMBINATION PEN INJECTION PRODUCTS

CHECK ONE:

COMPOUND NAME	STRENGTH/ML
☐ TIRZEPATIDE / PYRIDOXINE	25/5MG
SPECIAL INDICATION: NAUSEA OR OTHER INDICATION: _____	
☐ TIRZEPATIDE / GLYCINE	25/62.5MG
SPECIAL INDICATION: TISSUE REGENERATION, MUSCLE RECOVERY/ENERGY, AND IMPROVED COGNITIVE FUNCTION OR OTHER INDICATION: _____	

COMPOUND NAME	STRENGTH/ML
TIRZEPATIDE / CYANOCOBALAMIN ☐	25/6.25MG
SPECIAL INDICATION: BOOST METABOLISM AND ENERGY OR OTHER INDICATION: _____	
TIRZEPATIDE / NIACINAMIDE ☐	25/3MG
SPECIAL INDICATION: IMPROVED COLLAGEN PRODUCTION OR OTHER INDICATION: _____	

PEN INJECTION DIRECTIONS:

CHECK ONE:

TIRZEPATIDE COMBO DIRECTIONS

☐ Inject 2.5mg subcutaneously once weekly for weeks 1 through 4 then titrate to effect by 2.5mg every 4 weeks to a max dose of 15mg subcutaneously once weekly.

☐ Fulfill order with pen injector at _____ dose.

☐ Alternate Titration: _____

_____

_____

_____

TIRZEPATIDE COMBO PEN INJECTOR COST:

☐ $180.00 PER 1.2ML PEN (FOR DOSES 2.5MG - 7.5MG)

☐ $300.00 PER 2.4ML PEN (FOR DOSES 10MG - 15MG)

 # 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: _____