

Semaglutide/Glycine Injection Compounded Medication Order Form

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PATIENT					
First name		Last name		Date of birth	
Address			City, State, ZIP		
Primary phone		Secondary phone		Allergies	

SEMAGLUTIDE/GLYCINE INJECTION	
*MEDICAL RATIONALE REQUIRED (see below)	
☐ Semaglutide 1mg/ml / Glycine 5mg/ml Injection	
Sig: ☐ Weeks 1-4: Inject 0.25ml (25 units) once weekly ☐ 2ml (\$200)	
☐ Weeks 5-8: Inject 0.5ml (50 units) once weekly ☐ 2x2ml (\$300)	
☐ Weeks 9-12: Inject 1ml (100 units) once weekly ☐ 5ml (\$300)	
Refills: _____	

MEDICAL RATIONALE
Patient requires additional drug component that may support an underlying medical condition: ☐ chronic inflammation ☐ metabolic syndrome ☐ insulin resistance ☐ other: _____
Patient requires additional drug component that may decrease side effects: ☐ risk of muscle loss during weight loss ☐ fatigue ☐ other: _____
☐ Patient requires a dose that is not achievable with the commercially available drug

Additional formulas are available. Please contact the pharmacist at 419-784-4800 with any questions.

PRESCRIBER			
Prescriber name (print)		NPI #	DEA #
Address		City, State, ZIP	Phone
Prescriber signature			Date