Patient Information

Name____ DOB: ________________________________

Address: ____

City/State/Zip ________________________________ Email: ________________________________

Phone: ______________________________________ Allergies: _____________________________

Compounded Semaglutide Prescription

Compounded Semaglutide 2.5mg/ml 2ml/ *vial*

_______ *#Vials (2vials can be ordered*

Sig: **Inject-**

_____.25mg SQ weekly for 4 weeks	(10 syr. units)
_____.05m g SQ weekly for 4 weeks	(20 syr. units)
_____1 mg SQ weekly tor 4 weeks	(40 syr. units)
_____1.7mg SQ weekly for 4 weeks	(68 syr. units)
_____2.4m g SQ weekly	(96 syr. Units)

_____*Inject as Directed*

_______***Other:***

Refill_________vial (s)

Refills may be up to 11

Patient **Shipments**

'Syringe kit included ONLY when shipping to Patient.

*Requires COLD Next-Day Shipping @ $ 35.00

*Orders Auto-Ship within 24 hr when **billing Provider**

*Email sends tracking alerts.

*Have client call pharmacy 2 hours after Rx sent to confirm.

Office Shipments for Pt Instruction

*Requires COLD Next-Day Shipping @ 35.00

'Syringe kit included ONLY when shipping to Patient

Pharmacy Contact Cards Available upon Request

Bill to: Facility______ Patient______ Ship to: Facility______ Patient:_____

Facility ________________________________

Practitioner ______________________________

Address ________________________________

City/St/Zip______________________________

Phone__________________________________

____

Signature **Date**

PHONE: 205-438-9194 FAX: 855-559-5629 Email: AL@PhoenixMedsInc.com