

Weight-Loss Protocol
Order Form

TEL: 470-220-7232
 FAX: 470-220-7233
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WEST END
PHARMACY

Patient Information			
Name			DOB
Street Address		Phone	
City		State	ZIP
Sex	Allergies		

Pharmacy To Dispense			
Semaglutide-Niacinamide-Cyanocobalamin 2.5-2-0.5 mg/mL (MDV) (please choose Sig:)			
☐	Inject 10 UNITS (0.25 mg) SQ 1x week for 4 weeks and titrate UD		
☐	Inject 20 UNITS (0.5 mg) SQ 1x week for 4 weeks and titrate UD		
☐	Inject 40 UNITS (1 mg) SQ 1x week for 4 weeks and titrate UD		
☐	Inject 60 UNITS (1.5 mg) SQ 1x week for 4 weeks and titrate UD		
☐	Inject 80 UNITS (2 mg) SQ 1x week for 4 weeks and titrate UD		
☐	Inject 100 UNITS (2.5 mg) SQ 1x week for 4 weeks and titrate UD		
☐	Inject _____ UNITS SQ 1x week for 4 weeks and titrate UD		
Quantity	☐ 1 month	Other: _____ (60 day max)	# of refills: _____
Tirzepatide-Niacinamide-Cyanocobalamin 10-2-0.5 mg/mL (MDV) (please choose Sig:)			
☐	Inject 25 UNITS (2.5 mg) SQ 1x week for 4 weeks and titrate UD		
☐	Inject 50 UNITS (5 mg) SQ 1x week for 4 weeks and titrate UD		
☐	Inject 75 UNITS (7.5 mg) SQ 1x week for 4 weeks and titrate UD		
☐	Inject 100 UNITS (10 mg) SQ 1x week for 4 weeks and titrate UD		
☐	Inject 125 UNITS (12.5 mg) SQ 1x week for 4 weeks and titrate UD		
☐	Inject 150 UNITS (15 mg) SQ 1x week for 4 weeks and titrate UD		
☐	Inject _____ UNITS SQ 1x week for 4 weeks and titrate UD		
Quantity	☐ 1 month	Other: _____ (60 day max)	# of refills: _____

Prescriber Section			
This formulation combines a GLP-1 receptor agonist with Vitamin B12 and Vitamin B3 in a multidose vial, to meet the specific therapeutic needs of this individual patient. The inclusion of B12 and B3 is based on my clinical judgment of this patient's requirements. The multidose vial allows for flexible dose titration in both directions—either increasing or decreasing the dose as needed—to optimize treatment for this patient's unique condition. The pharmacy is directed to compound this preparation exclusively for the patient named in this prescription, with all dosing and administration to follow my specified instructions. 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.			
Practice Name			
Street Address			
City		State	ZIP
Phone		Fax	
Prescriber		Physician	NPI
Prescriber Signature		Date/Time	

Send the completed form to West End Pharmacy

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