John's PHARMACY

COMPOUNDED SEMAGLUTIDE | COMPOUNDED TIRZEPATIDE

Patient _____

DOB _____

Phone _____

Address _____

_____

Allergies _____

Prescriber _____

Phone _____

Fax _____

Address _____

_____

The directions provided below are at the sole request of the prescribing practitioner and are not a substitute for the practitioners medical judgment. Commercially available doses are not available. Cost is not a reason to compound. Medical necessity: John's Pharmacy does not compound copies of commercial product and requires a medical necessity to compound the below prescription.

Rx SUBLINGUAL SUSPENSION

☐ **Compound Semaglutide 6 mg/ml**
SIG: Take 0.5ml under the tongue for 5 minutes daily for 7 days then increase as tolerated up to 1ml daily or as directed by prescriber. # 30 ml Refills _____

☐ **Compound Tirzepatide 12.5 mg/ml**
SIG: Take 0.5ml under the tongue for 5 minutes daily for 7 days then increase as tolerated up to 1ml daily or as directed by prescriber. # 30 ml Refills _____

INJECTABLE

☐ **Compound Injection**
Semaglutide 2.7mg/ml Glycine 10mg/ml

DOSE (check box desired)

☐ 0.22mg ☐ 0.4mg ☐ 0.68mg
☐ 1.22mg ☐ 1.89mg ☐ 2.7mg

SIG: Inject _____ units SQ once a week for 4 weeks.
May increase dose as directed by prescriber.

#2 ml Refills _____

☐ **Compound Injection**
Tirzepatide 17mg/ml Glycine 10mg/ml

DOSE (check box desired)

☐ 1.7mg ☐ 3.4mg ☐ 5.95mg
☐ 8.5mg ☐ 11.9mg ☐ 17mg

SIG: Inject _____ units SQ once a week for 4 weeks.
May increase dose as directed by prescriber.

#2 ml Refills _____

REASON FOR COMPOUND

☐ This patient needs an alternative dose that is unavailable commercially, due to inability to tolerate the commercial product at the dosing available.

☐ This patient needs higher dosing than is commercially available to produce a significant therapeutic difference.

ANTI-NAUSEA

☐ **Ondansetron 4mg ODT**
SIG: Place one tablet on tongue and allow to dissolve every 4-6 hours as needed for nausea. Take first tablet 30 minutes prior to GLP injection.

10 Tabs Refills _____

INJECTION SUPPLIES

☐ _____ **pack(s) of injection supplies** ($5 per pack)
1 Pack contains (#10 (31 gauge 5/16") 1 mL insulin syringes + 10 alcohol swabs and patient instructions.

Prescriber's Signature _____ Date _____

☐ **Cape Girardeau**
2001 Independence St.
(573) 334-1300
FAX (573) 334-0493

☐ **Altenburg**
8491 Main St.
(573) 824-8888
FAX (573) 824-7777

☐ **Poplar Bluff**
909 W. Pine St.
(573) 785-0984
FAX (573) 785-2257

☐ **Puxico**
190 W. Richardson Ave.
(573) 222-6206
FAX (573) 222-6406

By signing above, I (the prescriber), agree that the patient named above is under my care and the above compounded prescription will have a significant difference for my patient. The formulas and/or statements listed are provided for educational purposes only. They are compounding ideas that have commonly been requested by physicians and have not been evaluated by the Food and Drug Administration. Formulas and/or materials listed are not to be interpreted as a promise, guarantee or claim of therapeutic efficacy or safety. The information contained herein is not intended to replace or substitute for conventional medical care or encourage its abandonment. Every patient is unique, and formulas should be adjusted to meet their individual needs. John's Pharmacy does not compound copies of commercially available products. No claims are made as to the safety, efficacy, or use of these ingredients or formulations.