GLP-1 Quick Order Form

Patient Full Name: ______________________________ DOB: ________________ Phone:____________________

Patient Address: ____ City: _______________________ State: ______

Semaglutide

- ☐ 5mg Vial (5mg/2mL)
- ☐ 10mg Vial (10mg/4mL)

Tirzepatide

- ☐ 20mg Vial (20mg/2mL)
- ☐ 40mg Vial (40mg/2mL)
- ☐ 60mg Vial (60mg/3mL)

(Directions for use and please indicate a route, quantity, and frequency (Ex: Inject 2mg SQ Q Weekly):

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Qty (# of Vials):________

Refills: **1** **2** **3** **4** **5** **PRN** **NONE** (CIRCLE AUTHORIZED REFILLS)

Physician Name: ___________________________________ NPI or DEA: _____________________________

Office Address:____ Office Phone Number: _______________________

Signature: ______________________________________ Date:__________________________________