

TIRZEPATDIE (10mg/mL and 20mg/mL) & Vitamin B6 (10mg/mL) ORDER FORM

| Patient Information | | | | |
|--|--|-------------|------------|--------------|
| Last Name: | | First Name: | | MI: |
| Address: | | | | Apt#: |
| City: | State: | Zip: | Phone#: | |
| DOB (mm/dd/yyyy): | Sex: M <input type="checkbox"/> F <input type="checkbox"/> | Email: | | |
| Drug Allergies: | | | | ICD-10: |
| Home Medications: | | | | |
| Prescriber Information | | | | |
| Prescriber's Name: | | | | |
| Phone#: | | | Fax#: | |
| Address: | | | | |
| City: | | | State: | Zip: |
| NPI: | | | DEA: | |
| Compounded Tirzepatide Injection | | | | |
| Write intended dose below. Titration will then increase according to schedule followed by a maintenance dose. | Administer each dose subcutaneously once weekly for 4 weeks into the abdomen (at least 2 inches from the navel), anterolateral thigh, or back of the upper arms. Rotate sites weekly. After 4 weeks, you may increase to the next dose if tolerated and at the discretion of your provider. Titration is to be followed by a maintenance dose. *Vial expires 28 days after opening* | | | |
| Tirzepatide (10mg/mL) & Vitamin B6 (10mg/mL) | | | | |
| Directions | Vial Size | # of Vials | Day Supply | # of Refills |
| Inject _____ mg once weekly x 4 weeks | <input type="checkbox"/> 1mL Vial NDC :54288-841-25 | | | |
| Inject _____ units once weekly x 4 weeks | <input type="checkbox"/> 3mL Vial NDC: 54288-804-25 | | | |
| Tirzepatide (20mg/mL) & Vitamin B6 (10mg/mL) | | | | |
| Directions | Vial Size | # of Vials | Day Supply | # of Refills |
| Inject _____ mg once weekly x 4 weeks | <input type="checkbox"/> 2mL Vial NDC :54288-841-25 | | | |
| Inject _____ units once weekly x 4 weeks | <input type="checkbox"/> 3mL Vial NDC: 54288-804-25 | | | |
| Optional Supportive Medications & Injection Supplies | | | | |
| Medication/ Supplies | | | | # of Refills |
| <input type="checkbox"/> Ondansetron ODT 4mg Dissolve 1 tablet on tongue every 4-6 hrs as needed for nausea #30 tablets | | | | |
| <input type="checkbox"/> Include syringes, needles, and injection supplies (e.g., alcohol wipes) | | | | |
| Unless listed on the FDA's drug shortage list, a prescriber must document a specific medical necessity for compound medications used in place of commercially available products. By signing this prescription, the prescriber affirms that any compounded medication requested on this form represents a clinically significant difference for the patient compared with commercially available products. | | | | |
| <input type="checkbox"/> Addition of vitamin B6 is intended to reduce GLP-1 associated nausea and improve patient tolerability. By checking this box, I have determined this compounded formula provides a clinically significant difference for this patient compared with commercially available products. | | | | |
| <input type="checkbox"/> Other (e.g. allergy, sensitivities, dosage requirements, or route of administration) _____ | | | | |

Date: _____

Signature: _____