WEIGHT LOSS

MR Compounding Pharmacy

Date: ________________________

Name: ____

Address: ____

Date of Birth: ___________________________ Telephone: ____

Allergies: ____

PLEASE CHECK ONE OF THE FOLLOWING:

SEMAGLUTIDE/CYANOCOBALAMIN - 5 MG / 1000 MCG/ML

☐	Month 1: Inject 5 units (0.25 mg / 0.2 mL) sq every week for 4 weeks	4 syringes	RF ________	$89
☐	Month 2: Inject 10 units (0.5 mg / 0.4 mL) sq every week for 4 weeks	4 syringes	RF ________	$120
☐	Month 3: Inject 20 units (1 mg / 0.8 mL) sq every week for 4 weeks	4 syringes	RF ________	$120
☐	Month 4: Inject 30 units (1.5 mg / 1.2 mL) sq every week for 4 weeks	4 syringes	RF ________	$140
☐	Month 5: Inject 50 units (2.5 mg / 2 mL) sq every week for 4 weeks	4 syringes	RF ________	$170

PLEASE READ AND CHECK THE FOLLOWING BOX:

☐ It is medically necessary to compound in Cyanocobalamin (B12) as energy boost for my patient. Please let me know if you need additional information to facilitate the process.

SUPPLIES: ALCOHOL PREP PADS

SHIPPING REQUIREMENT:

- ☐ To patient
- ☐ To doctor's office
- ☐ Patient pickup
- ☐ Bill patient
- ☐ Bill doctor's office

PROVIDER INFORMATION:

Name:____

Practice: ____

WEIGHT LOSS

Phone: ______________________________ Fax: ______________________________

Signature:____ Date: ______________

MR Compounding Pharmacy

Date: ______________________

Name: ____

Address: ____

Date of Birth: ______________________ Telephone: ______________________

Allergies: ____

CHECK ONE OF THE FOLLOWING:

TIRZEPATIDE/CYANOCOBALAMIN 16.6 MG / 1000 MCG/ML

☐	Month 1: Inject 15 units (2.5 mg / 0.6 mL) sq every week for 4 weeks	4 syringes	RF ________	$200
☐	Month 2: Inject 30 units (5 mg / 1.2 mL) sq every week for 4 weeks	4 syringes	RF ________	$220
☐	Month 3: Inject 45 units (7.5 mg / 1.8 mL) sq every week for 4 weeks	4 syringes	RF ________	$240
☐	Month 4: Inject 60 units (10 mg / 2.4 mL) sq every week for 4 weeks	4 syringes	RF ________	$260
☐	Month 5: Inject 75 units (12.5 mg / 3 mL) sq every week for 4 weeks	4 syringes	RF ________	$280
☐	Month 6: Inject 90 units (15 mg / 3.6 mL) sq every week for 4 weeks	4 syringes	RF ________	$300

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SHIPPING REQUIREMENT:

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☐ To doctor’s office

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WEIGHT LOSS

☐ Bill doctor's office

PROVIDER INFORMATION:

Name:____

Practice: ____

Phone: ____________________ Fax: ____________________

Signature:______________________________ Date: ____________