PRESCRIPTION FORM



PATIENT	PATIENT NAME:	DOB:	PHONE:	DX/ICD10:
ATI	ADDRESS:		ALLERGIES:	
▲				
PRESCRIPTION	1. Compound Semaglutide 2mg-1ml in SubMagna™ HMW #15ml			
	 INITIAL DOSE Place 0.25ml under tongue for 90 seconds minimum - swallow once daily, increase to 0.5ml on second week, do not eat for 30 minutes (<i>Recommended for new patients</i>) *STANDARD DOSE* Place 0.5ml under tongue for 90 seconds minimum - swallow once daily, do not eat for 30 minutes (<i>Recommended for new patients</i>) 			
	 Other			
	Refills: (Number of refills indicated here refers to al		above)	
		Zero		
	*Please note if a daily dose is missed the medication has a 7 day half life and no 'double dose' would be required the next day of administration.			
PRESCRIBER	PRESCRIBER'S SIGNATURE: DATE			
	FACILITY	CONTACT		PRESCRIBER'S NOTES
	ADDRESS	CITY/STATE/ZIP		1
	EMAIL	PHONE	FAX	1
	PRESCRIBER	NPI	DEA	
				ID:
				Updated 04_30_2021 om disclosure. Any review, discrimination or use of this transmission or any of its contents by person ioners to provide them with compounding options for their patients' medication challenges. No

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