PRESCRIPTION FORM

MYCELIUM PHARMACY

PATIENT

PATIENT NAME: _____ DOB: _____ PHONE: _____ DX/ICD10: _____

ADDRESS: _____ ALLERGIES: _____

PRESCRIPTION

☐ **1. Compound Semaglutide 2mg-1ml in SubMagna™ HMW #15ml**

☐ i. ***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 *(Recommended for new patients)*

☐ ii. ***STANDARD DOSE*** Place 0.5ml under tongue for 90 seconds minimum - swallow once daily, do not eat for 30 minutes *(Recommended for patients near or at target weight to maintain)*

☐ **2. Other** _____

(Medication, Directions, Quantity, Day Supply, Refills)

One does NOT have to use this order form for prescribing and could simply E-Prescribe through normal conventional systems should that be desired. In many ways, that can be easier for the prescriber. Call the pharmacy to discuss this further if you need any help adding the compound into your EMR system. Mycelium Pharmacy Ft. Lauderdale, FL 33334 Phone: 954-890-1150 Fax: 954-393-0670
Email: info@myceliumpharmacy.com (NCPDP: 1052416)

Refills: (Number of refills indicated here refers to all medications prescribed above)

☐ 1 Year ☐ 5 ☐ 3 ☐ 1 ☐ 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.

☐ **3. Optional add on**- Magna-Multi Daily Support Dietary Supplement (during weight loss)-30 Capsules

PRESCRIBER

PRESCRIBER'S SIGNATURE: _____ DATE _____

FACILITY	CONTACT	
ADDRESS	CITY/STATE/ZIP	
EMAIL	PHONE	FAX

PRESCRIBER		NPI	DEA
_____	☐	_____	_____
_____	☐	_____	_____
_____	☐	_____	_____

PRESCRIBER'S NOTES

ID:

Updated 04_30_2021