



PRESCRIPTION FORM

<b>PATIENT</b>	PATIENT NAME: _____ DOB: _____ PHONE: _____ DX/ICD10: _____
	ADDRESS: _____ ALLERGIES: _____

<b>PRESCRIPTION</b>	<p><b>1. Compound Semaglutide 2.0mg-.5ml in SubMagna™ HMW #15ml (14mg weekly dose)</b></p> <p>i. <b>*INITIAL DOSE*</b> 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>)</p> <p>ii. <b>*STANDARD DOSE*</b> Place 0.5ml under tongue for 90 seconds minimum - swallow once daily, do not eat for 30 minutes (<i>Recommended for patients near or at target weight to maintain</i>)</p> <p><input type="checkbox"/> <b>2. Custom Compound Semaglutide ____mg-.5ml in SubMagna™ HMW #15ml (____mg weekly dose)</b></p> <p><input type="checkbox"/> i. <b>*STANDARD DOSE*</b> Place 0.5ml under tongue for 90 seconds minimum - swallow once daily, do not eat for 30 minutes (<i>Recommended for patients near or at target weight to maintain</i>)</p> <p><b>3. Other</b> _____          (Medication, Directions, Quantity, Day Supply, Refills)</p> <p><b>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)</b></p> <p><b>Refills:</b> (Number of refills indicated here refers to all medications prescribed above)</p> <p>1 Year      5      3      1      Zero</p> <p>*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.</p> <p><input type="checkbox"/> <b>*4. Optional add ons (Check each)-</b> B12 1000mcg <input type="checkbox"/>    D 2000mcg <input type="checkbox"/>    BPC 157 500mcg <input type="checkbox"/>    Glycine 5000mcg <input type="checkbox"/></p> <p><input type="checkbox"/> <b>*5. Magna-Multi Daily Support Dietary Supplement</b> (Specifically for weight loss patients)-30 Capsules</p>
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<b>PRESCRIBER</b>	PRESCRIBER'S SIGNATURE: _____		DATE _____
	FACILITY	CONTACT	
	ADDRESS	CITY/STATE/ZIP	
	EMAIL	PHONE	FAX
	PRESCRIBER	NPI	DEA
			<p>PRESCRIBER'S NOTES</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div> <p style="text-align: right;">ID: _____</p> <p style="text-align: right; font-size: small;">Updated 04_30_2021</p>

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