

## Semaglutide Prescription Form

### Patient Information (Name, DOB, Telephone, Gender, Address, Allergies Required)

Patient: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender: Male / Female Email: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Medication Allergies (required): NKDA / Allergies: \_\_\_\_\_

3502 N Laurent  
Victoria, TX 77901  
Phone: 361-575-4713

Fax Form to: 361-573-9880



## Semaglutide/Pyridoxine Injections

### Semaglutide/Pyridoxine 1000mcg/25mg/mL Injection Solution

Month 1 – Inject 0.25mL (25 units) Sub-Q once weekly for 4 weeks (1 x 1mL vial)

Month 2 – Inject 0.50mL (50 units) Sub-Q once weekly for 4 weeks (1 x 2mL vial)

Month 3 – Inject 1mL (100 units) Sub-Q once weekly for 4 weeks (2 x 2mL vial)

### Semaglutide/Pyridoxine Needle Kit – BD Insulin Syringes 31g 5/16” 1mL (10 per pack)

### Physician Information

Prescriber Full Name: \_\_\_\_\_

Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

State License Number: \_\_\_\_\_ DEA Number: \_\_\_\_\_ NPI Number: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

I have reviewed my patient's medical history and have determined that the above compounded medication(s) are medically necessary. The compounded medication will better meet my patient's needs over a commercially available drug.

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Central Drug Compounding and Wellness specializes in personalized medication which can increase patient compliance to prescribers' treatment of choice. The FDA does not review these medications for safety or efficacy, but the facility is PCAB accredited for both sterile and nonsterile compounded medications. The facility does not compound medications that are available commercially.