



Send via: **832-592-1966**
 CarePoint Phone: **832-592-1776**
 Email: **admin@carepointfusionrx.com**

COMPOUNDED GLP-1 INJECTION – PRESCRIPTION / FAX ORDER FORM

Send via: E-Rx Fax Phone (verbal) **CarePoint Phone:** 832-592-1776
 CarePoint Phone: 832-592-1966 **Email:** admin@carepointfusionrx.com

1) PATIENT INFORMATION

Patient Name: _____
 DOB: ___/___/_____ Sex: M F Other
 Address: _____
 City/State/ZIP: _____
 Phone: _____ Email: _____
 Allergies: NKDA Yes (list): _____
 Diagnosis/ICD-10 (required): _____
 Height: _____ Weight: _____ BMI: _____

2) PRESCRIBER INFORMATION

Prescriber Name: _____
 Credentials: _____
 Practice/Clinic: _____
 Address: _____
 City/State/ZIP: _____
 Phone: _____ Fax: _____
 Email: _____
 NPI: _____ DEA (if required): _____
 State License #: _____ State: _____

3) MEDICATION SELECTION (COMPOUNDED – PATIENT SPECIFIC)

Semaglutide + Vitamin B12 (Injection)

- Select vial size/strength:**
- 2.5 mg / 0.5 mL (vial)
 - 5 mg / 1 mL (vial)
 - 1 mg / 1 mL (vial)
 - 2 mg / 1 mL (vial)

SIG (Directions):

- Month 1: 1ng 0mL/units) _____ once weekly
- Month 2: 1ng 0mL/units) _____ once weekly
- Month 3: 1ng 0mL/units) _____ once weekly
- Month 4: 1ng 0mL/units) _____ once weekly
- Month 5: 1ng 0mL/units) _____ once weekly
- Dispense qty: _____

Tirzepatide + Vitamin B12 (Injection)

- Select vial size/strength:**
- 2.5 mg / 0.5 mL (vial) once weekly for ____
 - 5 mg / 1 mL (vial) once weekly for ____
 - 10 mg / 2 mL (vial) once weekly for ____ weeks only
 - 20 mg / 1 mL (concentration) once weekly for ____
 - Other: _____

Refills: ____ or 0 _____

5) OPTIONAL SUFTARET (1≠ F APPLY)

- Ondansetron ODT** _____ mg
- SIG** 1 tab PO/ODT q ____ hrs PRN nausea/vomiting
- Other: ____ Refills: _____

4) SUPPLIES (CHECK ALL THAT APPLY)

- Include syringes/needles suitable for prescribed dose/volume
- Sharps container
- Alcohol prep pads
- Other: _____

6) DISPENSE INSTRUCTIONS

- Dispense as Written (DAW)**
- Substitution Permitted**
- Patient counseling requested: Yes: No

7) PRESCRIBER ATTESTATION / SIGNATURE

Prescriber Signature: _____
 Date: ___/___/_____

* Optional component based on patient's nausea/vomiting history as determined by prescriber.