Patient Name: _____ DOB: _____ Date: _____

Address: _____ City: _____ State: _____
Zip: _____

Phone:_____

Semaglutide 5mg/2ml

Quantity (choose one): ☐ 2ml ☐ 4ml ☐ 6ml ☐ 8ml

Sig:

☐ Inject 0.25mg (0.1ml) SQ weekly

☐ Inject 0.5mg (0.2ml) SQ weekly

☐ Inject 1mg (0.4ml) SQ weekly

☐ Inject 1.7mg (0.68ml) SQ weekly

☐ Inject 2mg (0.8ml) SQ weekly

☐ Inject 2.4mg (0.96 ml) SQ weekly

Directions:

Notes:

Signature: _____
Prescriber: _____ Phone: _____
Clinic: _____ DEA: _____
Address: _____

Please **print**, **sign** and **fax** form to 970-663-7478 CLEAR FORM