

# Tirzepatide Prescription Order Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Allergy: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ License/ID: \_\_\_\_\_

This Compounded Medication is Medically Necessary	Dose	Quantity	Instructions
<p><i>Select one</i></p> <p><input type="checkbox"/> <u>Tirzepatide/Cyanocobalamin (B12)</u></p>	<p><i>Select one</i></p> <p>12.5mg—0.5mg/mL</p>	<p><i>Select one</i></p> <p><input type="checkbox"/> 1 Vial</p> <p><input type="checkbox"/> 2 Vials</p> <p><input type="checkbox"/> 3 Vials</p>	<p><i>Select one</i></p> <p><input type="checkbox"/> 2.5mg – Inject 20 units (0.2mL) subcutaneously weekly for 4 weeks (4mL vial)</p> <p><input type="checkbox"/> 5mg – Inject 40 units (0.4mL) subcutaneously weekly for 4 weeks (4mL vial)</p> <p><input type="checkbox"/> 7.5mg – Inject 60 units (0.6mL) subcutaneously weekly for 4 weeks (4mL vial)</p> <p><input type="checkbox"/> 10mg – Inject 80 units (0.8mL) subcutaneously weekly for 4 weeks (4mL vial)</p> <p><input type="checkbox"/> 12.5mg – Inject 100 units (1mL) subcutaneously weekly for 4 weeks (4mL vial)</p> <p><input type="checkbox"/> ____mg – Inject ____ units subcutaneously weekly for 4 weeks (4mL vial)</p>
<p><i>Select one</i></p> <p><input type="checkbox"/> <u>Tirzepatide/Pyridoxine (B6)</u></p>	<p><i>Select one</i></p> <p>12.5mg—50mg/mL</p>	<p><i>Select one</i></p> <p><input type="checkbox"/> 1 Vial</p> <p><input type="checkbox"/> 2 Vials</p> <p><input type="checkbox"/> 3 Vials</p>	<p><i>Select one</i></p> <p><input type="checkbox"/> 2.5mg – Inject 20 units (0.2mL) subcutaneously weekly for 4 weeks (4mL vial)</p> <p><input type="checkbox"/> 5mg – Inject 40 units (0.4mL) subcutaneously weekly for 4 weeks (4mL vial)</p> <p><input type="checkbox"/> 7.5mg – Inject 60 units (0.6mL) subcutaneously weekly for 4 weeks (4mL vial)</p> <p><input type="checkbox"/> 10mg – Inject 80 units (0.8mL) subcutaneously weekly for 4 weeks (4mL vial)</p> <p><input type="checkbox"/> 12.5mg – Inject 100 units (1mL) subcutaneously weekly for 4 weeks (4mL vial)</p> <p><input type="checkbox"/> ____mg – Inject ____ units subcutaneously weekly for 4 weeks (4mL vial)</p>

Dr. Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_ License \_\_\_\_\_

NPI # \_\_\_\_\_ Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

With the recent resolution of the tirzepatide shortage, we will no longer compound commercially available tirzepatide products. However, we will continue to provide a **custom compounded tirzepatide formulation** only for patients with **specific medical needs** that cannot be addressed with the commercial product. These may include, but are not limited to:

- |   |  |
|---|--|
| <input type="checkbox"/> Intolerance to rapid titration due to severe gastrointestinal effects (e.g., nausea, vomiting) | <input type="checkbox"/> Need for alternative strengths, delivery systems, or inactive ingredient profiles |
| <input type="checkbox"/> Fatigue or metabolic insufficiency   | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Unintended muscle loss   |  |

## By signing this prescription, you acknowledge that:

The patient has a documented clinical need for a compounded version of tirzepatide

The commercial product is **not appropriate or sufficient** for this patient

You are requesting this compounded medication as a **personalized therapy** under your professional judgment

**⚠ This compounded preparation is provided under Section 503A of the Federal Food, Drug, and Cosmetic Act. It is not FDA-approved and is dispensed only with a valid patient-specific prescript.**