



COMPOUNDED INJECTABLE GLP-1 RX ORDER FORM

West Towne Pharmacy
1619 West Market St.
Johnson City, TN 37604
P: 423-926-9137
F: 423-926-7321

PATIENT NAME: _____ DOB: _____ PHONE: _____

ADDRESS: _____

ALLERGIES: _____

Please complete the above demographics or send in a face sheet.

GLP-1 INJECTABLES

Semaglutide 2.5mg/mL Injection Solution MDV

QTY #2mL. #4mL. #6mL) **\$260/2mL**

SIG: Inject ____ mg or ____ mLs subcutaneously once a week.

NAUSEA

Ondansetron 4mg ODT Tablets (QTY #10 #30)

SIG: Place 1 tablet on the tongue, allow to dissolve then swallow every 8 hours as needed for nausea.

PRESCRIBER NAME:

NPI:

DEA:

ADDRESS:

PHONE:

FAX:

CONTACT PERSON:

PRESCRIBER SIGNATURE:

DATE:

REFILLS:



WEST TOWNE PHARMACY
1619 WEST MARKET ST.
JOHNSON CITY, TN 37604
P: 423-926-9137
F: 423-926-7321

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Semaglutide 2.5mg/mL Injection Solution MDV
QTY #2mL #4mL #6mL ****\$260/2mL****
SIG: Inject ___ mg or ___ mLs SQ once a week.

Ondansetron 4mg ODT Tablets
QTY #10 #30

SIG: Place 1 tablet on the tongue, allow to dissolve then swallow every 8 hours as needed for nausea.

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NPI/DEA: _____ PHONE: _____

PRESCRIBER SIGNATURE: _____

DATE: _____ REFILLS: _____



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