

Send To: 6054 Livernois Rd Troy, MI 48098		FAX FORM TO: (800) 766 - 1956	Pharmacy Phone (877) 531 - 1147
DATE / /	DATE OF BIRTH / /		
PATIENT NAME		PATIENT PHONE ()	

<input type="checkbox"/> Semaglutide/Cyanocobalamin 2mg-0.4mg/mL	QTY: 1mL	REFILLS: ____
SIG: Inject (circle one) 0.125mL (0.25mg) 0.25mL (0.5mg) ____mL once weekly		
<input type="checkbox"/> 31G 5/16" 0.3mL Syringes	QTY: ____ pack(s)	(10 syringes per pack)
SIG: Use as directed		
<input type="checkbox"/> Semaglutide/Cyanocobalamin 5mg-0.4mg/mL	QTY: 2mL	REFILLS: ____
SIG: Inject (circle one) 0.2mL (1mg) 0.3mL (1.5mg) 0.4mL (2mg) 0.5mL (2.5mg) ____mL once weekly		
<input type="checkbox"/> 31G 5/16" 0.5mL Syringes	QTY: ____ pack(s)	(10 syringes per pack)
SIG: Use as directed		
<input type="checkbox"/> Ondansetron 4mg Orally Disintegrating Tablet (ODT)	QTY: ____	REFILLS: ____
SIG: Dissolve 1 tablet in mouth as directed for nausea		

***E-Scribe Instructions:**

Please select "unable to find" and specify in notes section exactly which strength to dispense, either Semaglutide/Cyanocobalamin 2mg-0.4mg/mL or 5mg-0.4mg/mL. Write in how many milligrams patient is to inject weekly.

For reference only, not a valid prescription. Please use this as a guide to call in, write, or prescribe via EMR. Email us at support@univrx.com to request a copy of this form for your practice.