Semaglutide Dosing Prescription

Toll Free Phone Number : 800-407-7421
Toll Free Fax Number : 800-308-8573

2209 SW 104th St Suite E, Oklahoma City, OK, 73159

This prescription form is to be sent & received via fax

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ___/___/___	SS#: ___-___-___
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other:	Wt.: Ht.:

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment

Therapy Start Date	Date of Transplant	Date of Discharge	Date Medication Needed

Other/Concomitant Medications (please list)

Allergies ☐ NKDA ☐ Drug Allergies (please list) ☐ Other (please list)

Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained

ICD-10 Codes ☐ Kidney (Z94.0) ☐ Kidney/Pancreas (Z94.0/Z94.83) ☐ Heart (Z94.1) Lung (Z94.2) ☐ Heart/Lung (Z94.3) ☐ Liver (Z94.4) ☐ Bone Marrow (Z94.81) ☐ Intestines (Z94.82) ☐ Pancreas (Z94.83) ☐ B25 CMV disease ☐ B25.9 CMV disease, unspecified ☐ Other Code _____ Description _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite Brand Necessary or Brand Medically Necessary or your state-specific required language to prohibit substitutions This form is not a valid prescription form for writing controlled medications

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Semaglutide	☐ 2 mg/mL ☐ 3 mg/mL	Select Flavors We are pleased to offer a selection of delicious flavors for your enjoyment: Marshmallow Strawberry Grape Cherry Spearmint Bubblegum Dosing Options Please select the required dose: 0.25 mL 0.5 mL 0.75 mL 1 mL ☐ Other Rx Sig: _____	QS	

To Prescriber: By signing this form and utilizing our services, you are also authorizing Eaglet Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber: **Date:** ___/___/___

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.