TOWN & COUNTRY
Compounding Pharmacy
We compound quality

Semaglutide & Tirzepatide Order Form
Town & Country Compounding Pharmacy
535 E Crescent Ave, Ramsey, NJ 07446
Toll-Free Phone: 800-850-2101 **Phone/Text:** 201-447-2020 **Fax:** 201-447-3253
pharmacist@tccompound.com | tccompound.com

PHARMACY COMPOUNDING ACCREDITATION BOARD
ACCREDITED

Patient Name		**Prescriber Name**	
Date of Birth		Office Phone #	
Phone #		Office Fax #	
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Allergies		NPI	
Email		DEA	

2/24

How to Send a Prescription to Town & Country Compounding Pharmacy
1. Write prescription on prescription pad or this order form and fax over to 201-447-3253 OR email to pharmacist@tccompound.com.
2. E-Scribe to "Town **&** Country Compounding **&** Consultation." Make sure our address is 535 E Crescent Avenue, Ramsey, NJ 07446.
3. Call in prescription to 201-447-2020 (option 1).

☐ Send to **PATIENT** **OR** ☐ Send to **OFFICE**
☐ Charge **PATIENT** **OR** ☐ Charge **OFFICE**

Note: Semaglutide & Tirzepatide can be compounded pursuant to a patient specific prescription while the commercially manufactured product is on national shortage determined by the FDA. / **Note**: Store Semaglutide & Tirzepatide injections in a refrigerator at 36°F to 46°F (2°C to 8°C) and away from heat, moisture and light. Discard any unused medication after the beyond-use date. / **Note**: Store Semaglutide sublingual suspension at room temperature 68°F to 77°F (20°C to 25°C) and away from heat, moisture and light. Discard any unused medication after the beyond-use date.

SEMAGLUTIDE 1 MG/ML SUBLINGUAL SUSPENSION

☐ 15 mL ☐ 30 mL Refill # _____

☐ Start at 0.25 mL (0.25 mg) sublingually once a day for 1 week. Then, increase to 0.5 mL (0.5 mg) daily. May titrate up to 1 mL (1 mg) daily. Hold liquid under the tongue for at least 60 seconds or as long as possible, then swallow any remainder.

☐ Other: _____

SEMAGLUTIDE MULTI-DOSE VIAL

			Refill
☐ MONTH **1**	**0.25 MG** subcutaneously once a week	2 mg/mL – 1 mL Vial	# _____
☐ MONTH **2**	**0.5 MG** subcutaneously once a week	2 mg/mL – 1 mL Vial	# _____
☐ MONTH **3**	**1 MG** subcutaneously once a week	2 mg/mL – 1 mL Vial x 2	# _____
☐ MONTH **4**	**1.7 MG** subcutaneously once a week	5 mg/mL – 2 mL Vial	# _____
☐ MONTH **5** (AND ONWARDS)	**2.4 MG** subcutaneously once a week	5 mg/mL – 2 mL Vial	# _____

TIRZEPATIDE 20 MG/ML MULTI-DOSE VIAL

Refill # _____

Sig: Inject **(MUST SELECT A DOSE BELOW)** mg subcutaneously once a week

☐ 2.5 mg (1 x 1 mL) ☐ 5 mg (1 x 1 mL) ☐ 7.5 mg (2 x 1 mL) ☐ 10 mg (2 x 1 mL) ☐ 12.5 mg (3 x 1 mL) ☐ 15 mg (3 x 1 mL)

Prescriber Signature: _____ **Date Written:** _____