MIDTOWN
Express Pharmacy

Weightloss Focused Order Form

Phone (615) 320-8414
Fax (615) 807-3135

Patient's Name:	**Prescriber's Name:**
Street Address:	Supervising Prescriber:
City, State ZIP:	Street Address:
Date of Birth:	City, State ZIP:
Phone #:	Office #: Fax #:
Allergies:	NPI #:

PRESCRIBER'S SIGNATURE:____ **DATE:**__________

1. ______ **CMP-Semaglutide 1mg/ml Sublingual Liquid #15ml**
   SIG: Place 0.3ml under the tongue once a day for 1 month, then increase to 0.5ml daily or as directed by prescriber.

2. ______ **Ondansetron ODT 4mg #30**
   SIG: Place 1 tablet on the tongue and let it dissolve; may repeat dose every 4-6 hours as needed for nausea/vomiting.

REFILLS:______