NEW PRESCRIPTION ORDER FORM

1 Patient Information

Last Name	First Name	MI
Address		Apt. #
City / State / ZIP / Phone Number		
Date of Birth (mm/dd/yyyy) / Sex ○ M ○ F / Email		

2 Prescriber and Prescription Information

Prescriber's Name		
Phone Number	Fax Number	
Street Address		
City	State	ZIP
NPI	DEA	

Semaglutide Sublingual Suspension (SubMagna™ SL HMW) – Higher Strength

DO NOT USE FOR NEW PATIENTS – START AT LOW DOSE

Target Dose		
1.75 mg	○ **Semaglutide 2.5 mg/mL SL Suspension** **QTY**: 5ml Administer 0.7 ml under tongue once weekly, ensuring it is held for a minimum for 1 minute before swallowing. Increase dosage if ineffective after 4 weeks.
2 mg	○ **Semaglutide 2.5 mg/mL SL Suspension** **QTY**: 5ml Administer 0.8 ml under tongue once weekly, ensuring it is held for a minimum for 1 minute before swallowing. Increase dosage if ineffective after 4 weeks.
2.25 mg	○ **Semaglutide 2.5 mg/mL SL Suspension** **QTY**: 5ml Administer 0.9 ml under tongue once weekly, ensuring it is held for a minimum for 1 minute before swallowing. Increase dosage if ineffective after 4 weeks.
2.4 mg	○ **Semaglutide 3 mg/mL SL Suspension** **QTY**: 5ml Administer 0.8 ml under tongue once weekly, ensuring it is held for a minimum for 1 minute before swallowing. Increase dosage if ineffective after 4 weeks.
	○ **Semaglutide ____ mg/mL SL Suspension** **QTY**: ___ ml Administer ____ ml under tongue once weekly, ensuring it is held for a minimum for 1 minute before swallowing. Increase dosage if ineffective after 4 weeks.

Not For New Patients

Do not use this order form for new patients.

These high strengths are for well-established treatment plans with lower doses being ineffective.

Caution with Dosage

Given semaglutides 5-7 day half-life, start with lower dose to reduce prolonged side effects, then gradually increase to effective dose.

Known Dose Requests

If the current dosage is effective, maintain it. If your dose is missing, fill in the necessary details in the last formula.

You can also E-Prescribe, or call in the prescription to our pharmacists to expedite service.

***SL HMW** = Sublingual High Molecular Weight*

Other Directions: _____

Refills: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12 ○ Other _____

x _____ _____

Prescriber's Signature Date

3 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

_____ _____

Pharmacy Name Pharmacy Fax Number

The pharmacy name & fax # cannot be pre-printed in order to comply with RI Law 216-RICR-40-15-1 section 1.3A10

Form SLS-01.0