COMPOUND ORDER FORM

WILMONT
PHARMACY & SURGICALS

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone _____

Allergies: _____

Low Dose Naltrexone - Take 1 capsule by mouth once daily

Naltrexone 3mg	Quantity: _____	Refills: _____	
Naltrexone 4.5mg	Quantity: _____	Refills: _____	

Sexual Health- Take 1 capsule 30 mins prior to sexual activity

Sildenafil 55mg	Quantity: _____	Refills: _____	
Sildenafil 105mg	Quantity: _____	Refills: _____	
Sildenafil 30mg + **Tadalafil** 7mg	Quantity: _____	Refills: _____	
Sildenafil 55mg + **Tadalafil** 12mg	Quantity: _____	Refills: _____	

Sublingual GLP-1- Take 1ml sublingually once daily

Semaglutide SL 1mg/ml - 28ml (28 doses)	Quantity: _____	Refills: _____	
Semaglutide SL 2mg/ml - 28ml (28 doses)	Quantity: _____	Refills: _____	
Semaglutide SL 3mg/ml - 28ml (28 doses)	Quantity: _____	Refills: _____	
Semaglutide SL 4mg/ml - 28ml (28 doses)	Quantity: _____	Refills: _____	
Semaglutide SL 5mg/ml - 28ml (28 doses)	Quantity: _____	Refills: _____	

Injectable GLP-1- Inject once a week subcutaneously

Semaglutide 0.25mg/0.05ml x 4 weeks	Quantity: _____	Refills: _____	
Semaglutide 0.5mg/0.1ml x 4 weeks	Quantity: _____	Refills: _____	
Semaglutide 1mg/0.2ml x 4 weeks	Quantity: _____	Refills: _____	
Semaglutide 1.7mg/0.34ml x 4 weeks	Quantity: _____	Refills: _____	
Semaglutide 2mg/0.4ml x 4 weeks	Quantity: _____	Refills: _____	
Semaglutide 2.4mg/0.48ml x 4 weeks	Quantity: _____	Refills: _____	
Tirzepatide 2.5mg/0.125ml x 4 weeks	Quantity: _____	Refills: _____	
Tirzepatide 5mg/0.25ml x 4 weeks	Quantity: _____	Refills: _____	
Tirzepatide 7.5mg/0.375ml x 4 weeks	Quantity: _____	Refills: _____	
Tirzepatide 10mg/0.5ml x 4 weeks	Quantity: _____	Refills: _____	
Tirzepatide 12.5mg/0.625ml x 4 weeks	Quantity: _____	Refills: _____	
Tirzepatide 15mg/0.75ml x 4 weeks	Quantity: _____	Refills: _____	

Hormone Support- Take 1 capsule by mouth once daily

DHEA 25mg	Quantity: _____	Refills: _____	
DHEA 50mg	Quantity: _____	Refills: _____	
DHEA 75mg	Quantity: _____	Refills: _____	
DHEA 100mg	Quantity: _____	Refills: _____	

*Compounded medications are not reviewed by the FDA for safety or efficacy.

Prescriber Signature: _____ **DEA #** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Date:** _____

Phone: _____ **Fax:** _____

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