



# WEIGHT LOSS RX ORDER FORM

- ALL PRICING IS SUBJECT TO CHANGE -

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
Street Address City State Zip

Patient Phone: \_\_\_\_\_

Bupropion	Strength	Order	_____	Strength	Order	Topiramate	Strength	Order
Bupropion	80mg	<input type="radio"/>	_____	5mg	<input type="radio"/>	Topiramate	15mg	<input type="radio"/>
Bupropion	120mg	<input type="radio"/>	_____	7.5mg	<input type="radio"/>	Topiramate	30mg	<input type="radio"/>
Bupropion	160mg	<input type="radio"/>	_____	10mg	<input type="radio"/>	Topiramate	____mg	<input type="radio"/>
Bupropion	____mg	<input type="radio"/>	_____	15mg	<input type="radio"/>			
			_____	20mg	<input type="radio"/>			
			_____	____mg	<input type="radio"/>			

Naltrexone	Strength	Order	Zonisamide	Strength	Order	7-Keto DHEA	Strength	Order
Naltrexone	4mg	<input type="radio"/>	Zonisamide	45mg	<input type="radio"/>	7-Keto DHEA	15mg	<input type="radio"/>
Naltrexone	8mg	<input type="radio"/>	Zonisamide	60mg	<input type="radio"/>	7-Keto DHEA	25mg	<input type="radio"/>
Naltrexone	____mg	<input type="radio"/>	Zonisamide	75mg	<input type="radio"/>	7-Keto DHEA	____mg	<input type="radio"/>
			Zonisamide	____mg	<input type="radio"/>			

**SIG:** Take 1 capsule QD as directed by physician.

Quantity: # 30 \_\_\_\_\_ # 60 \_\_\_\_\_ # 90 \_\_\_\_\_ # \_\_\_\_\_

SIG: \_\_\_\_\_

**REFILLS** \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider Phone: \_\_\_\_\_

Provider Address: \_\_\_\_\_  
Street Address Apt/Ste City State Zip

NPI #: \_\_\_\_\_ DEA#: \_\_\_\_\_

Provider Signature: \_\_\_\_\_