RHETT WOMEN'S CENTER

Weight Management (Semaglutide/Tirzepatide) Prescription Drug Management Consent

This document is intended to serve as a confirmation of informed consent for compounded Semaglutide/Tirzepatide, which is a prescription weight management medication.

Patient Informed Consent:

I understand that this is a completely self-pay medication, and it will not be run through insurance, no prior authorization will be done or letters of medical necessity.

I voluntarily request that RWC providers treat my medical condition.

I have informed my provider of any known allergies, my medical conditions, medications, and social/family history.

I have the right to be informed of any alternative options, side effects, and the risks and benefits.

I understand how it is to be administered.

I understand the prescription will come from a compounding pharmacy, which is not FDA approved. I have been told that the manufacturing facility itself is FDA monitored along with third party testing on the medication itself.

Prices may vary and change. My monthly charge will include my once a month treatment and care to monitor my medication progress with RWC providers, staff, supplies, and medication.

RWC providers may change the pharmacy based on several factors (availability, shipping time, cost).

It has been explained to me that this medication could be harmful if taken inappropriately or without advice from the provider.

I understand this medication may cause adverse side effects (see below). I understand this list is not complete and it describes the most common side effects, and that death is also a possibility of taking this medication. I understand symptoms may be worse after there has been a change in my medication dose or when first start the medication.

Common side effects include, but are not limited to:

- Gastrointestinal: nausea/vomiting, abdominal pain, diarrhea/constipation, dyspepsia, abdominal distension, eructation, flatulence, gastroenteritis, GERD, gastritis, lipase increase, amylase increase
- Neurological: headache, dizziness
- Cardiac: heart rate increase, hypotension
- Endocrine: fatigue, hypoglycemia (diabetic patients), alopecia
- Ophthalmic: retinal disorder (diabetic patients)
- Skin: redness or pain at injection site

Serious Reactions include, but are not limited to:

- Thyroid C-cell tumor (animal studies)
- Medullary thyroid cancer
- Hypersensitivity reaction
- Anaphylaxis
- Angioedema
- Acute kidney injury
- Chronic renal failure exacerbation
- Pancreatitis
- Cholelithiasis
- Cholecystitis

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- Syncope

I understand I have the following responsibilities:

Medical History: I will tell RWC providers my complete medical history, including: allergies, medications, medical/surgical/social/family history.

- RWC providers may ask to review, with your permission, your medical history (medications, recent lab results, pertinent imaging results).
- I understand that if I become pregnant or start trying for pregnancy, I must stop this medication.
- I will be honest to the best of my ability the history RWC providers need to know.
- I will tell my provider any updated health information (medication, allergies, personal medical issues/surgeries/social history, or family history changes).
- My provider can discuss my treatment plan with any co-treating pharmacist and/or healthcare provider.
- I will always tell other providers about all medications I am taking.

- RWC providers may ask for me to seek additional labs while on treatment to ensure its safety.

- I understand I will stay well hydrated during this treatment program.

Directions for use: I will take my medications only as prescribed according to the directions by RWC providers.

- If I feel my medications are not effective, or are causing undesirable side effects, I will contact my provider for instructions.
- I will not adjust my medications without prior instruction to do so.
- I understand that the medication must be kept refrigerated.
- I understand this medication must be self-injected in the subcutaneous tissue once weekly. I will not inject any less than 7 days unless directed otherwise by RWC providers.
- The first injection will be given in-office and I will wait 15-20 minutes in office after injection has been given to ensure I don't have any immediate side effects. I will also be given instructions on how to use injections.
- I will not share needles and will dispose of needles safely.
- If I'm having trouble with the administration of the medication, I will seek help from RWC providers.
- The medication expires after 12 weeks.

Refills:

- All refills will require an appointment.
- I understand I may need to schedule refill appointments ahead of time to avoid delays in refills.
- I will not ask for early refills.
- I understand that I may be asked to bring the medication with me to my appointments to check the quantity left or assess how I am injecting.

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Safety:

- I understand it is important to keep my medication away from children (<18 years old).
- I am the only one who will use my medication. I will not give or sell my medication to anyone else.

If RWC providers deems it appropriate to start weaning my medication or transition to maintenance dosing, I will comply.

Discontinuation of medication:

I understand that RWC providers may stop prescribing my medications if:

- I am having unfavorable side effects or it's not working to treat my medical condition (no weight loss or weight gain).
- I have been untruthful in my medical or family history.
- I do not follow through with the recommended plan of care set by RWC providers.

I have read this form in its entirety. It has been explained to me. I have had the opportunity to ask questions and have all my questions answered. I fully understand the above information and have no further questions. By signing this form, I voluntarily give my consent for treatment and agree to the risks.

Patient Signature _____ Date _____

Provider Signature _____ Date _____

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