

Weight Management Prescription Drug Management Consent

Semaglutide / Tirzepatide

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

A. Patient Informed Consent

1. I voluntarily request that Whitesboro Family Medical Clinic treats my medical condition.
2. I have informed my provider of any known allergies, my medical conditions, medications, social/family history.
3. I have the right to be informed of any alternative options, side effects, and the risks and benefits.
4. I understand the mechanism of action of the medication and how it is to be administered.
5. I understand the prescription will come from a compounding pharmacy, which is not FDA approved. Prices may vary and change.
6. It has been explained to me that this medication could be harmful if taken inappropriately or without advice from the provider.
7. 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 starting 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) or Medullary thyroid cancer
- Acute kidney injury
- Chronic renal failure exacerbation
- Hypersensitivity reaction
- Pancreatitis
- Anaphylaxis
- Cholelithiasis/Cholecystitis
- Angioedema
- Syncope

B. I understand that I have the following responsibilities

1. Medical history: I will tell the provider my complete medical history, including: allergies, medications, medical/surgical/social/family history.
 - a. I understand that if I become pregnant or start trying for pregnancy, I must stop this medication. I will not take this medication if I am breastfeeding.
 - b. I will be honest to the best of my ability the history she needs to know.
 - c. I will tell my provider any updated health information (medication, allergies, personal medical issues/surgeries/social history, or family history changes).
 - d. My provider can discuss my treatment plan with any co-treating pharmacist and/or healthcare provider and I will always tell other providers about all medications I am taking.
 - e. My provider may ask for me to seek additional labs while on treatment to ensure its safety.
2. Directions for use: I will take my medications only as prescribed according to the directions

- a. If I feel my medications are not effective, or are causing undesirable side effects, I will contact my provider for instructions.
- b. I will not adjust my medications without prior instruction to do so.
- c. 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 by the provider.
- e. I will not share needles and dispose of needles safely.
- f. If I'm having troubles with the administration of the medication, I will seek help from the prescribing provider.

3. Refills:

- a. 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.

4. Safety:

- a. 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 my provider deems it appropriate to start weaning my medication or transition to maintenance dosing, I will comply.

C. Discontinuation of medication: I understand that my provider may stop prescribing my medications if:

- a. I am having unfavorable side effects or it's not working to treat my medical condition, if I have been untruthful in my medical or family history, if I do not follow through with the recommended plan of care set by the provider at Whitesboro Family Medical Clinic, or I do not follow any parts of "Part B: Responsibilities" in this agreement.

Every client is an individual, and it is not possible to determine in advance how your system will react to the treatment. It is sometimes necessary to adjust your program as we proceed. It is your responsibility to do your part by following healthy dietary guidelines, exercise your body and make necessary behavioral modifications.

• **Semaglutide/Tirzepatide may cause serious side effects, including:**

- Possible thyroid tumors, including cancer. Tell your health care provider if you get a lump or swelling in your neck, hoarseness, trouble swallowing, or shortness of breath. These may be symptoms of thyroid cancer. In studies with rodents, semaglutide and medicines that work like semaglutide caused thyroid tumors, including thyroid cancer. It is not known if Semaglutide will cause thyroid tumors, or a type of thyroid cancer called medullary thyroid carcinoma (MTC) in people. Do not use Semaglutide if you or any of your family have ever had MTC, or if you have an endocrine system condition called Multiple Endocrine Neoplasia syndrome type 2 (MEN 2).

• **Do not use Semaglutide/Tirzepatide if:**

- You or any of your family has ever had MTC or if you have MEN 2.
- You are allergic to Semaglutide/Tirzepatide or any of the ingredients in Semaglutide/Tirzepatide
- Have or have had problems with your pancreas or kidneys.
- Have a history of diabetic retinopathy.
- Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements.

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.

Name: _____ Signature: _____ Date: _____