

NEW PRESCRIPTION ORDER FORM

1 Patient Information *** For Terminally Ill Hospice Patient***

Last Name		First Name		MI
Address				Apt. #
City	State	ZIP	Phone Number	
Date of Birth (mm/dd/yyyy)		Sex	Email	
		<input type="radio"/> M <input type="radio"/> F		

2 Prescriber and Prescription Information

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



Prescribing Form – Non-Sterile Hospice Compounded Medication

☐ Fentanyl 50 mcg-mL Nasal Spray

Directions/SIG

- ☐ Spray 1 spray into one nostril every 2 hours as needed for severe pain.
- ☐ Spray 1 spray into one nostril every 4 hours; may repeat once after 15 minutes if inadequate relief.
- ☐ Use 1 spray intranasally every 2–4 hours for breakthrough pain.
- ☐ Other _____

Quantity _____ Refills _____

X _____
Prescriber's Signature Date

3 Fax it to Bayview Pharmacy at (401) 284-4506 or to our alternative fax (401) 210-2757.