



Your modern compounding pharmacy.™

This standardized order form helps ensure accurate, safe, and efficient prescribing of customized compounded medications. Please review the brief instructions below before completing or submitting any form.

## For Prescribers

### 1. Select the Formulation

Fill in the bubble next to the intended compounded product.

### 2. Choose Directions/SIG

Select one of the provided SIG options or write custom instructions.

### 3. Complete Patient Information

Include full name, DOB, address, phone number, and other information.

### 4. Fill in Prescriber Information

Include your NPI, DEA (if required), phone, fax, and address.

### 5. Sign and Date

Unsigned forms cannot be processed.

### 6. Fax Completed Forms

Send to (401) 284-4506 or (401) 210-2757.

## For Patients & Caregivers

- **Give this form directly to your healthcare provider.** They must complete and sign it before Bayview Pharmacy can prepare your medication.
- You may receive this form from a provider or facility; bring it to your next appointment if it has not yet been completed.
- Do **not** fill out the prescriber sections yourself. Your provider will enter your dosing instructions and clinical details.
- After we receive the prescription, we will reach out to the patient to go over the medication, allergies, shipping/pickup, and payment.

3844 Post Road, Warwick RI 02886

Phone: 401-284-4505

Fax: 401-284-4506

Alternate Fax: 401-210-2757

[www.bayviewrx.com](http://www.bayviewrx.com)

# NEW PRESCRIPTION ORDER FORM

## 1 Patient Information

|                            |       |                                                 |              |        |
|----------------------------|-------|-------------------------------------------------|--------------|--------|
| 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 – Compounded Medication

☐ Nifedipine 0.2% Rectal Ointment

### Directions/SIG

- ☐ Apply a small amount to the anal area twice daily.
- ☐ Apply a thin layer to the affected area three times daily and after bowel movements.
- ☐ Insert a pea-sized amount rectally twice daily for symptom relief.
- ☐ 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.

We are currently licensed to service patients residing in **RI, MA, CT, NY, NJ, NH, and FL.**

Unfortunately, we are unable to fulfill prescriptions for patients outside of our service area.