Bayview Pharmacy

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

NEW PRESCRIPTION ORDER FORM

Bayview Pharmacy

1 Patient Information

Last Name	First Name	MI
Address		Apt. #

City	State	ZIP	Phone Number
Date of Birth (mm/dd/yyyy)	Sex ○ M ○ F		Email

2 Prescriber and Prescription Information

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

℞

Prescribing Form – Compounded Medication

○ **Clobetasol Propionate 0.05% Oral Rinse**

Directions/SIG

- ○ Swish 5 mL in the mouth for 2 minutes, then spit; use twice daily.
- ○ Swish 5–10 mL for 1–2 minutes up to three times daily as directed.
- ○ Rinse with 5 mL after meals and at bedtime; do not swallow.
- ○ Other _____
  _____

Quantity

○ 120 mL ○ 180 mL ○ 240 mL ○ Other _____

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.