

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	
		☐ M ☐ F		

2 Prescriber and Prescription Information

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



Prescribing Form – Compounded Medication

☐ Niacinamide 4% Topical Gel

Directions/SIG

- ☐ Apply a thin layer to the affected area once daily.
- ☐ Apply to affected skin twice daily as directed.
- ☐ Apply a small amount to the affected area nightly at bedtime.
- ☐ Other _____

Quantity

- ☐ 30 g ☐ 45 g ☐ 60 g ☐ 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.