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 ○ 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

○ **Niacinamide 4%/Metronidazole 1% Topical Cream**

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.