

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

☐ Naltrexone HCl 4.5 mg Capsules

Directions/SIG

- ☐ Take 1 capsule by mouth once daily at bedtime.
- ☐ Take 1 capsule by mouth every morning as directed.
- ☐ Take 1 capsule by mouth once daily for symptom support.
- ☐ Other _____

Quantity

- ☐ 30 caps ☐ 60 caps ☐ 90 caps ☐ 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.