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 – Triple-P Urethral Gel (Alprostadil / Papaverine / Phentolamine)

Alprostadil mcg/mL with papaverine 7.5 mg/mL / phentolamine 1 mg/mL — 0.25 mL per dose

◯ Triple-P 250 (250 mcg/mL) ◯ Triple-P 750 (750 mcg/mL)

◯ Triple-P 500 (500 mcg/mL) ◯ Triple-P 1000 (1000 mcg/mL)

QTY ◯ 4 doses ◯ 8 doses ◯ Sample pack (titration) ◯ Other _____

Send to: ◯ **PATIENT** ◯ **OFFICE** **Charge to:** ◯ **PATIENT** ◯ **OFFICE** *Ship / bill preference*

Directions:

◯ Administer single dose (0.25 mL) into opening of penis once daily and no more than three times a week, as directed.

◯ Starting with lowest strength, administer single dose into opening of penis once daily and no more than three times a week as directed; 24 hours between trials.

◯ Other _____

_____

Refills: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 Other: _____

X _____ _____

Prescriber's Signature Date

3 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

_____ _____

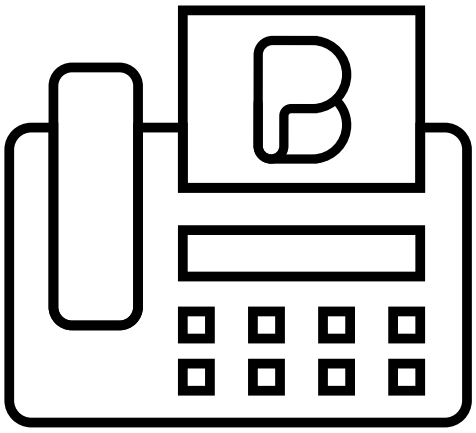
Pharmacy Name Pharmacy Fax Number

The pharmacy name & fax # cannot be pre-printed in order to comply with RI Law 216-RICR-40-15-1 section 1.3A10

Bayview Pharmacy

Your modern compounding pharmacy.™

FAX COVER SHEET



Please fax your order to:

401-284-4506

3844 Post Road, Warwick RI 02886

Phone: 401 - 284 - 4505

www.bayviewrx.com