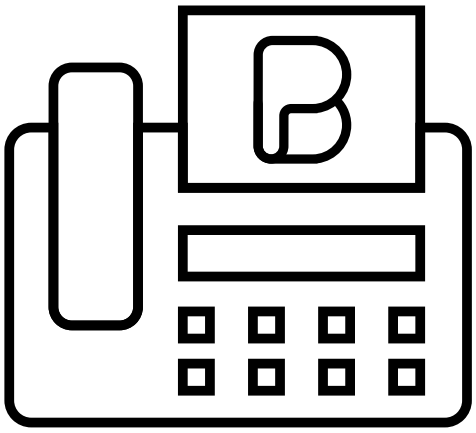
Bayview Pharmacy

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

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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

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Prefer to skip the fax? Bayview Pharmacy accepts electronic prescriptions from all major EHR and e-prescribing platforms on the Surescripts network. Here's how to send your prescription electronically in three quick steps.

How to E-Prescribe

1. **Search for our pharmacy**
   In your EHR or e-prescribing platform, search the pharmacy directory for "Bayview Pharmacy" — or search by ZIP code 02886 and look for us in Warwick, RI.

2. **Verify you have the right location**
   Confirm the listing matches the details in the box below before selecting it.

3. **Enter the prescription and send**
   Enter the compounded medication exactly as it appears on the order form — product, strength, quantity, directions, and refills — then transmit. No fax needed; we take it from there.

Pharmacy Name	Bayview Pharmacy
Address	3844 Post Road, Warwick, RI 02886
NCPDP ID	4106882
NPI	1750455143
Phone	(401) 284-4505
Fax	(401) 284-4506

If your EHR requires a free-text compound entry, type the formulation name exactly as it appears in the Rx section of the order form.

Questions? Call (401) 284-4505 and one of our pharmacists will walk you through it.

NEW PRESCRIPTION ORDER FORM – FOOT PAIN, HEEL SPURS & NEUROPATHY (1 OF 2)

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 Information

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

3 Medication Selection

NEUROPATHIC & MIXED FOOT PAIN – Transdermal Cream or Gel (select one formula)	QUANTITY
☐ FTP-ADG Amitriptyline 2% / diclofenac 5% / gabapentin 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ FTP-DGL Diclofenac 5% / gabapentin 10% / lidocaine 7%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ FTP-GKL Gabapentin 10% / ketoprofen 20% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ FTP-KGTB Ketoprofen 10% / gabapentin 10% / tizanidine 0.2% / baclofen 2%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ FTP-KGCN Ketoprofen 10% / gabapentin 6% / clonidine 0.2% / nifedipine 2% (ischemic / neuropathic)	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ FTP-GCB Gabapentin 10% / clonidine 0.2% / baclofen 1% (burning foot)	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ FTP-FAGLP Flurbiprofen 10% / amitriptyline 1% / gabapentin 6% / lidocaine 2% / prilocaine 2%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ FTP-G6 Gabapentin 6%	QTY: ☐ 60 ☐ 120 ☐ 180 gm

CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ gm

REFILLS (circle one)

1 2 3 4 5 6 7 8 9 10 PRN NR

DIRECTIONS/SIG + SIGNATURE

☐ Apply 1–2 mL (1–2 pumps) to the affected area 3–4 times daily as needed.

☐ Apply a thin layer to the affected area every 8 hours as needed for pain.

☐ Other _____

X _____ _____

Prescriber's Signature Date

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

_____ _____

Pharmacy Name

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

Pharmacy Fax Number

NEW PRESCRIPTION ORDER FORM – FOOT PAIN, HEEL SPURS & NEUROPATHY (2 OF 2)

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 Information

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

3 Medication Selection

HEEL SPURS / PLANTAR FASCIITIS / TENDON – Cream or Gel (select one formula)	QUANTITY
☐ HSP-ABK Amitriptyline 2% / baclofen 2% / ketoprofen 10%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ HSP-KTB Ketoprofen 10% / tizanidine 0.2% / bupivacaine 1%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ HSP-KC Ketoprofen 10% / cyclobenzaprine 2%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ HSP-IBU Ibuprofen 20%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ HSP-KET Ketoprofen 10%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ HSP-D10 Diclofenac 10%	QTY: ☐ 60 ☐ 120 ☐ 180 gm

FOOT CRAMPS / GOUT (select one formula)	QUANTITY
☐ FCR-GM Guaifenesin 10% / magnesium sulfate 10% cream	QTY: ☐ 60 ☐ 120 gm
☐ FCR-MG Magnesium chloride 10% / peppermint oil 1% cream	QTY: ☐ 60 ☐ 120 gm
☐ GOU-ITC Indomethacin 2% / tetracaine 2% / colchicine 0.2% cream	QTY: ☐ 60 ☐ 120 gm

CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ gm

REFILLS (circle one)

1 2 3 4 5 6 7 8 9 10 PRN NR

DIRECTIONS/SIG + SIGNATURE

☐ Apply 1–2 mL (1–2 pumps) to the affected area 3–4 times daily as needed.

☐ Apply a thin layer to the affected area every 8 hours as needed for pain.

☐ Other _____

X _____ _____

Prescriber's Signature Date

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

_____ _____

Pharmacy Name

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Pharmacy Fax Number

NEW PRESCRIPTION ORDER FORM – NAIL FUNGUS & NAIL REMOVAL

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 Information

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

3 Medication Selection

NAIL FUNGUS – Penetrating Nail Solution (DMSO) (select one formula)	QUANTITY
☐ NAL-TI Terbinafine 3% / itraconazole 1% nail solution	QTY: ☐ 15 ☐ 30 mL
☐ NAL-FU Fluconazole 1% / urea 20% nail solution	QTY: ☐ 15 ☐ 30 mL
☐ NAL-FI Fluconazole 2% / ibuprofen 2% nail solution (mild-moderate)	QTY: ☐ 15 ☐ 30 mL
☐ NAL-KET Ketoconazole 2% nail solution (mild-moderate)	QTY: ☐ 15 ☐ 30 mL
☐ NAL-II Itraconazole 2% / ibuprofen 2% nail solution (moderate-severe)	QTY: ☐ 15 ☐ 30 mL
☐ NAL-IUTS Itraconazole 2% / undecylenic acid 17% / tea tree oil 16.7% / salicylic acid 10% nail solution (severe)	QTY: ☐ 15 ☐ 30 mL
☐ NAL-CIFT Ciclopirox 8% / itraconazole 3% / ibuprofen 2% / fluconazole 3% / terbinafine 1% nail solution (severe)	QTY: ☐ 15 ☐ 30 mL
☐ NAL-THY Thymol 4% in alcohol	QTY: ☐ 15 ☐ 30 mL
☐ NAL-EKC Erythromycin 2% / ketoconazole 2% / ciprofloxacin 1% nail solution (mixed infection)	QTY: ☐ 15 ☐ 30 mL
NAIL REMOVAL / NAIL PSORIASIS (select one formula)	**QUANTITY**
☐ NAL-UREA40 Urea 40% / lactic acid 10% / salicylic acid 3% cream (nail softening / chemical avulsion)	QTY: ☐ 30 ☐ 60 gm
☐ NAL-CLOB8 Clobetasol 8% nail gel	QTY: ☐ 30 ☐ 60 gm
CUSTOM – (other formula or strength – call pharmacy to confirm)	**QUANTITY**
☐ _____	QTY: _____ gm

REFILLS (circle one)

1 2 3 4 5 6 7 8 9 10 PRN NR

DIRECTIONS/SIG + SIGNATURE

☐ Apply to the affected nail(s) and surrounding skin twice daily; file the nail weekly.

☐ Apply to the nail under occlusion nightly for _____ weeks.

☐ Other _____

X _____ _____

Prescriber's Signature Date

4 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

NEW PRESCRIPTION ORDER FORM – CORNS, CALLUSES, DRY & SWEATY FEET (1 OF 2)

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 Information

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

3 Medication Selection

CORNS & CALLUSES (select one formula)	QUANTITY
☐ CRN-SPT Salicylic acid 10% / podophyllin 10% / trichloroacetic acid 10% solution (provider-applied, in office)	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
☐ CRN-SM Salicylic acid 20% / menthol 0.1% cream	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
☐ CRN-SUA Salicylic acid 5% / urea 20% / ammonium lactate 12% cream	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL

ROUGH / DRY FEET (select one formula)	QUANTITY
☐ DRY-U40 Urea 40% / lactic acid 10% / salicylic acid 3% cream	QTY: ☐ 60 ☐ 120 ☐ 240 gm
☐ DRY-U20 Urea 20% gel	QTY: ☐ 60 ☐ 120 ☐ 240 gm
☐ DRY-U8 Urea 8% cream	QTY: ☐ 60 ☐ 120 ☐ 240 gm
☐ DRY-HU Sodium hyaluronate 0.5% / urea 10% gel	QTY: ☐ 60 ☐ 120 ☐ 240 gm

CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ gm

OFFICE USE – provider-applied or office-stocked items

Charge to: ☐ Patient ☐ Office **Ship to:** ☐ Patient ☐ Office ☐ Patient pick-up

REFILLS (circle one)

1 2 3 4 5 6 7 8 9 10 PRN NR

DIRECTIONS/SIG + SIGNATURE

☐ Apply to the affected area(s) once or twice daily.

☐ Apply a thin layer to the feet at bedtime; wash off in the morning.

☐ Provider applies in office.

☐ Other _____

X _____ _____

Prescriber's Signature Date

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

_____ _____

Pharmacy Name

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Pharmacy Fax Number

NEW PRESCRIPTION ORDER FORM – CORNS, CALLUSES, DRY & SWEATY FEET (2 OF 2)

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 Information

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

3 Medication Selection

SWEATY FEET (HYPERHIDROSIS) (select one formula)	QUANTITY
☐ SWT-G05 Glycopyrrolate 0.5% solution (roll-on)	QTY: ☐ 30 ☐ 60 gm/mL
☐ SWT-G1C Glycopyrrolate 1% cream	QTY: ☐ 30 ☐ 60 gm/mL
☐ SWT-G1L Glycopyrrolate 1% lotion	QTY: ☐ 30 ☐ 60 gm/mL
☐ SWT-G2 Glycopyrrolate 2% wipes / solution	QTY: ☐ 30 ☐ 60 gm/mL

CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ gm/mL

OFFICE USE – provider-applied or office-stocked items

Charge to: ☐ Patient ☐ Office **Ship to:** ☐ Patient ☐ Office ☐ Patient pick-up

REFILLS (circle one)

1 2 3 4 5 6 7 8 9 10 PRN NR

DIRECTIONS/SIG + SIGNATURE

☐ Apply to the affected area(s) once or twice daily.

☐ Apply a thin layer to the feet at bedtime; wash off in the morning.

☐ Provider applies in office.

☐ Other _____

X _____ _____

Prescriber's Signature Date

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

_____ _____

Pharmacy Name

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Pharmacy Fax Number

NEW PRESCRIPTION ORDER FORM – DIABETIC TOES, CIRCULATION & RAYNAUD'S

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 Information

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

3 Medication Selection

CIRCULATION / RAYNAUD'S – Cream or Gel (select one formula)	QUANTITY
☐ CIR-N4 Nifedipine 4% cream	QTY: ☐ 60 ☐ 120 gm
☐ CIR-N16 Nifedipine 16% cream	QTY: ☐ 60 ☐ 120 gm
☐ CIR-P5 Pentoxifylline 5% cream	QTY: ☐ 60 ☐ 120 gm
☐ CIR-P5N2 Pentoxifylline 5% / nifedipine 2% cream	QTY: ☐ 60 ☐ 120 gm
☐ CIR-P3N3 Pentoxifylline 3% / nifedipine 3% cream	QTY: ☐ 60 ☐ 120 gm
☐ CIR-NTG Nitroglycerin 0.2% cream (digital ulcers / Raynaud's)	QTY: ☐ 60 ☐ 120 gm
☐ CIR-KGCN Ketoprofen 10% / gabapentin 6% / clonidine 0.2% / nifedipine 2% cream (painful ischemic toes)	QTY: ☐ 60 ☐ 120 gm
☐ CIR-NPK Nifedipine 10% / pentoxifylline 5% / ketoprofen 10% / gabapentin 6% / lidocaine 3% / prilocaine 3% cream	QTY: ☐ 60 ☐ 120 gm

CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ gm

REFILLS (circle one)

1 2 3 4 5 6 7 8 9 10 PRN NR

DIRECTIONS/SIG + SIGNATURE

☐ Apply 1 mL to the affected toes/fingers 3–4 times daily.

☐ Apply a thin layer to the affected area twice daily and before cold exposure.

☐ Other _____

X _____ _____

Prescriber's Signature Date

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

_____ _____

Pharmacy Name

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

Pharmacy Fax Number