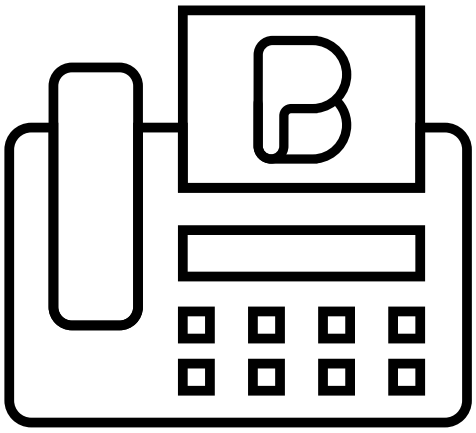
Bayview Pharmacy

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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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 – TOPICAL PAIN (INFLAMMATORY, MUSCULAR, NEUROPATHIC) (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

INFLAMMATORY PAIN – Cream or Gel (select one formula)	QUANTITY
☐ TPI-D10 Diclofenac 10%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPI-DL Diclofenac 10% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPI-K10 Ketoprofen 10%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPI-KL Ketoprofen 10% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPI-LK20 Lidocaine 20% / ketoprofen 20% ointment	QTY: ☐ 60 ☐ 120 ☐ 180 gm
INFLAMMATORY & MUSCULAR PAIN (select one formula)	**QUANTITY**
☐ TPM-CDL Cyclobenzaprine 2% / diclofenac 10% / lidocaine 10%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPM-CKL Cyclobenzaprine 2% / ketoprofen 10% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPM-CDLM Cyclobenzaprine 2% / diclofenac 3% / lidocaine 2% / magnesium chloride 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPM-C2 Cyclobenzaprine 2%	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; do not apply to broken skin.

☐ 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 – TOPICAL PAIN (INFLAMMATORY, MUSCULAR, NEUROPATHIC) (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

NEUROPATHIC & MIXED PAIN (select one formula)	QUANTITY
☐ TPN-DGL Diclofenac 5% / gabapentin 10% / lidocaine 7%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPN-ADG Amitriptyline 2% / diclofenac 5% / gabapentin 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPN-GKL Gabapentin 10% / ketoprofen 20% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPN-CGKL Cyclobenzaprine 2% / gabapentin 6% / ketoprofen 15% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPN-BGKL Baclofen 2% / gabapentin 6% / ketoprofen 10% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPN-GLB Gabapentin 6% / lidocaine 5% / bupivacaine 2%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPN-G6 Gabapentin 6%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPN-SHN Acyclovir 5% / amitriptyline 2% / bupivacaine 1% / gabapentin 6% / ketoprofen 5% (shingles / post-herpetic)	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPN-KAC Ketamine 6% / amitriptyline 4% / cyclobenzaprine 5% (Schedule III - EPCS only)	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; do not apply to broken skin.

☐ 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 – PELVIC & PROCEDURE PAIN

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

PELVIC PAIN – Topical or Rectal (select one formula)	QUANTITY
☐ PLV-IBU20 Ibuprofen 20% cream (external use)	QTY: ☐ 30 ☐ 60 ☐ 12 gm/count
☐ PLV-K10 Ketoprofen 10% cream	QTY: ☐ 30 ☐ 60 ☐ 12 gm/count
☐ PLV-KC Ketoprofen 10% / cyclobenzaprine 2% cream	QTY: ☐ 30 ☐ 60 ☐ 12 gm/count
☐ PLV-IBUS Ibuprofen 600 mg suppository	QTY: ☐ 30 ☐ 60 ☐ 12 gm/count

PROCEDURE / PRE-INJECTION ANESTHETIC – Cream or Gel (select one formula)	QUANTITY
☐ PRA-LT23 Lidocaine 23% / tetracaine 7% plasticized ointment	QTY: ☐ 30 ☐ 60 ☐ 120 gm
☐ PRA-BLT Benzocaine 20% / lidocaine 8% / tetracaine 4% plasticized gel	QTY: ☐ 30 ☐ 60 ☐ 120 gm
☐ PRA-BLT10 Benzocaine 20% / lidocaine 10% / tetracaine 10% gel	QTY: ☐ 30 ☐ 60 ☐ 120 gm
☐ PRA-LP Lidocaine 5% / prilocaine 5% gel	QTY: ☐ 30 ☐ 60 ☐ 120 gm
☐ PRA-L30 Lidocaine 30% plasticized	QTY: ☐ 30 ☐ 60 ☐ 120 gm
☐ PRA-T4 Tetracaine 4% gel	QTY: ☐ 30 ☐ 60 ☐ 120 gm

Also available as the dedicated BLT Numbing Cream order form. High-strength anesthetics are for provider-supervised use on intact skin.

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 a thin layer to the area 30–45 minutes before the procedure; remove before treatment.

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

☐ Insert 1 suppository rectally every 8 hours as needed.

☐ 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