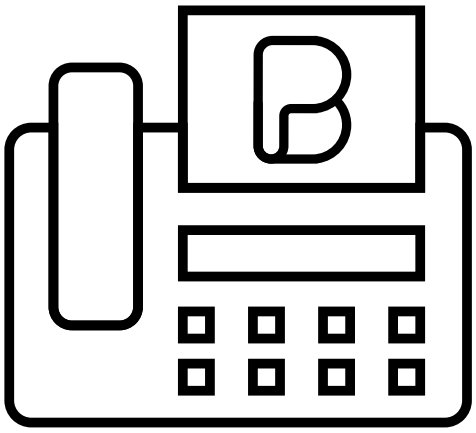
Bayview Pharmacy

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

Bayview Pharmacy

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 – VAGINAL INFECTIONS

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

YEAST / CANDIDA (incl. C. glabrata) – Vaginal (select one formula)	QUANTITY
☐ VIN-BOR600 Boric acid 600 mg vaginal suppository	QTY: ☐ 14 ☐ 30 count/gm
☐ VIN-BOR30 Boric acid 30% vaginal gel or cream	QTY: ☐ 14 ☐ 30 count/gm
☐ VIN-BORE Boric acid 30% / edetate disodium 0.5% vaginal gel (biofilm)	QTY: ☐ 14 ☐ 30 count/gm
☐ VIN-AMB50 Amphotericin B 50 mg vaginal suppository	QTY: ☐ 14 ☐ 30 count/gm
☐ VIN-NYS Nystatin 100,000 units vaginal suppository	QTY: ☐ 14 ☐ 30 count/gm
☐ VIN-FLUC Fluconazole 150 mg / boric acid 600 mg vaginal suppository	QTY: ☐ 14 ☐ 30 count/gm

BACTERIAL VAGINOSIS / MIXED – Vaginal (select one formula)	QUANTITY
☐ VBV-MN Metronidazole 1% / nystatin 100,000 u/g vaginal cream	QTY: ☐ 30 ☐ 60 ☐ 14 gm/count
☐ VBV-CHX Chlorhexidine 0.5% / 0.625% vaginal gel (circle)	QTY: ☐ 30 ☐ 60 ☐ 14 gm/count
☐ VBV-CIP Ciprofloxacin 2% vaginal gel	QTY: ☐ 30 ☐ 60 ☐ 14 gm/count
☐ VBV-CLIN Clindamycin 2% vaginal cream	QTY: ☐ 30 ☐ 60 ☐ 14 gm/count
☐ VBV-ACE Acetic acid 0.9% / hydroxyquinoline 0.025% vaginal gel	QTY: ☐ 30 ☐ 60 ☐ 14 gm/count
☐ VBV-ASC Ascorbic acid 25% vaginal gel	QTY: ☐ 30 ☐ 60 ☐ 14 gm/count
☐ VBV-MUP Mupirocin 10 mg / 20 mg vaginal suppository (circle)	QTY: ☐ 30 ☐ 60 ☐ 14 gm/count

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

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

- ☐ Insert 1 suppository vaginally at bedtime for 14 nights.
- ☐ Insert 1 applicator (2 g) vaginally at bedtime for 14 nights.
- ☐ Insert 1 g vaginally once daily for 14 days.
- ☐ 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 – VAGINAL DRYNESS, ATROPHY & LIBIDO

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

NON-HORMONAL MOISTURIZERS – Vaginal (for estrogen options see the Estrogen Vaginal form) (select one formula)	QUANTITY
☐ VDR-HA Sodium hyaluronate 5 mg/g vaginal gel	QTY: ☐ 30 ☐ 60 ☐ 30 gm/count
☐ VDR-VITE Vitamin E 200 IU vaginal suppository or 200 u/g gel (circle)	QTY: ☐ 30 ☐ 60 ☐ 30 gm/count
☐ VDR-GLY Glycerin / caprylic-capric triglyceride vaginal suppository	QTY: ☐ 30 ☐ 60 ☐ 30 gm/count
☐ VDR-AEH Vitamin A 0.1% / vitamin E 0.1% / sodium hyaluronate 0.5% vaginal cream	QTY: ☐ 30 ☐ 60 ☐ 30 gm/count
☐ VDR-DHEA DHEA 13 mg/g vaginal gel or 6.5 mg vaginal suppository (circle)	QTY: ☐ 30 ☐ 60 ☐ 30 gm/count

LIBIDO / AROUSAL – Vaginal Cream (metered pump) (select one formula)	QUANTITY
☐ LIB-AT Arginine 6% / theophylline 2.5% vaginal cream (scream cream)	QTY: ☐ 30 ☐ 60 gm
☐ LIB-ATS Arginine 6% / theophylline 2.5% / sildenafil 2% vaginal cream	QTY: ☐ 30 ☐ 60 gm
☐ LIB-SN Sildenafil 3% / nitroglycerin 0.2% vaginal cream	QTY: ☐ 30 ☐ 60 gm
☐ LIB-OXY Oxytocin 120 units/g vaginal gel	QTY: ☐ 30 ☐ 60 gm
☐ LIB-OXC Oxytocin 20 units/g cream	QTY: ☐ 30 ☐ 60 gm
☐ LIB-PA Papaverine 0.1% / arginine 6% topical cream	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

- ☐ Insert 1 g (1 pump) vaginally at bedtime; then 2–3 times weekly.
- ☐ Apply 0.5 mL (1 pump) to the clitoris 15–30 minutes before intercourse.
- ☐ Insert 1 suppository vaginally at bedtime.
- ☐ 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 – VULVAR CONDITIONS & PROCEDURE ANESTHETIC (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

VULVAR LICHEN SCLEROSUS / ITCHING – Cream (select one formula)	QUANTITY
☐ VUL-CLOB Clobetasol 0.05% vulvar cream	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ VUL-TAC Tacrolimus 0.03% vulvar cream	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ VUL-KNT Ketotifen 0.05% / naltrexone 0.5% / tacrolimus 0.03% vulvar cream	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ VUL-NAL Naltrexone 1% vaginal cream (itching)	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ VUL-KN Ketotifen 0.05% / naltrexone 1% vaginal cream (itching)	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ VUL-ESHA Estriol 0.3% / sodium hyaluronate vulvar cream	QTY: ☐ 30 ☐ 45 ☐ 60 gm
VAGINAL PROCEDURE ANESTHETIC (provider-applied; e.g. laser / MonaLisa Touch) (select one formula)	**QUANTITY**
☐ VPA-LT Lidocaine 23% / tetracaine 7% cream	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ VPA-BLT Benzocaine 20% / lidocaine 8% / tetracaine 4% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ VPA-LP Lidocaine 5% / prilocaine 5% gel	QTY: ☐ 30 ☐ 45 ☐ 60 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 a pea-sized amount to the affected area(s) twice daily.

☐ Provider applies to the vaginal/vulvar area 20–30 minutes before the procedure.

☐ Insert 1 g vaginally _____ times daily.

☐ 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 – VULVAR CONDITIONS & PROCEDURE ANESTHETIC (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

PELVIC PAIN / VAGINISMUS – Vaginal Cream (see also Vulvodynia form) (select one formula) **QUANTITY**

☐ VAG-AB	Amitriptyline 2% / baclofen 2% vaginal cream	**QTY:** ☐ 30 ☐ 60 ☐ 15 gm/count
☐ VAG-AGL	Amitriptyline 2% / gabapentin 6% / lidocaine 2% vaginal cream	**QTY:** ☐ 30 ☐ 60 ☐ 15 gm/count
☐ VAG-GL	Gabapentin 6% / lidocaine 2.5% vaginal cream	**QTY:** ☐ 30 ☐ 60 ☐ 15 gm/count
☐ VAG-BDL	Baclofen 2% / diazepam 1% / gabapentin 6% / lidocaine 2% vaginal cream (Schedule IV – EPCS only)	**QTY:** ☐ 30 ☐ 60 ☐ 15 gm/count
☐ VAG-DKL	Diazepam 1% / ketamine 5% / lidocaine 5% vaginal cream (Schedule III – EPCS only)	**QTY:** ☐ 30 ☐ 60 ☐ 15 gm/count
☐ VAG-DBS	Diazepam 5 mg / baclofen 10 mg vaginal suppository (Schedule IV – EPCS only)	**QTY:** ☐ 30 ☐ 60 ☐ 15 gm/count

CUSTOM – (other formula or strength – call pharmacy to confirm) **QUANTITY**

☐ _____ **QTY:** _____ gm/count

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 pea-sized amount to the affected area(s) twice daily.

☐ Provider applies to the vaginal/vulvar area 20–30 minutes before the procedure.

☐ Insert 1 g vaginally _____ times daily.

☐ 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 – ENDOMETRIOSIS, CERVICAL DYSPLASIA & NIPPLE CARE

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

ENDOMETRIOSIS / PROGESTERONE – Vaginal (select one formula)	QUANTITY
☐ END-DAN Danazol 10% vaginal gel	QTY: ☐ 30 ☐ 30 gm/count
☐ END-PRGS Progesterone 100 mg vaginal suppository	QTY: ☐ 30 ☐ 30 gm/count
☐ END-PRG200 Progesterone 200 mg vaginal suppository	QTY: ☐ 30 ☐ 30 gm/count
☐ END-PRGG Progesterone 10% vaginal gel	QTY: ☐ 30 ☐ 30 gm/count
CERVICAL DYSPLASIA – Topical Gel (provider-applied) (select one formula)	**QUANTITY**
☐ CVD-G20 Gowey tincture 20% gel	QTY: ☐ 30 ☐ 60 gm
☐ CVD-G30 Gowey tincture 30% gel	QTY: ☐ 30 ☐ 60 gm
NIPPLE CARE (BREASTFEEDING) – Ointment (select one formula)	**QUANTITY**
☐ APNO-STD All-purpose nipple ointment: mupirocin 1% / betamethasone 0.05% / miconazole 2%	QTY: ☐ 30 ☐ 60 gm
☐ APNO-NYS Mupirocin 1% / betamethasone 0.05% / nystatin 100,000 u/g ointment (miconazole-free)	QTY: ☐ 30 ☐ 60 gm
☐ APNO-LAN Lanolin 50% / lidocaine 2% nipple cream	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

- ☐ Insert 1 suppository vaginally at bedtime.
- ☐ Apply sparingly to nipples after each feeding; do not wash off before the next feeding.
- ☐ 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