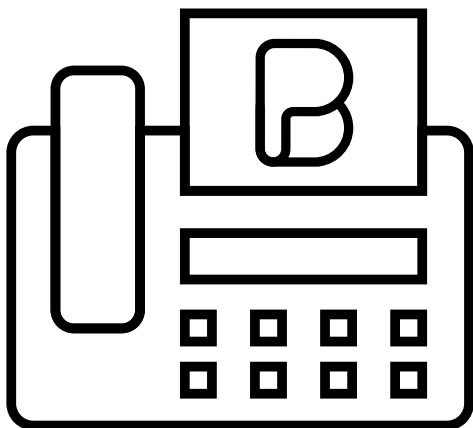




Your modern compounding pharmacy.™

FAX COVER SHEET



Please fax your order to:

401-284-4506

3844 Post Road, Warwick RI 02886

Phone: 401 - 284 - 4505

www.bayviewrx.com



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



Your modern compounding pharmacy. TM

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.

3844 Post Road, Warwick RI 02886
Phone: 401-284-4505
Fax: 401-284-4506
Alternate Fax: 401-210-2757
www.bayviewrx.com

NEW PRESCRIPTION ORDER FORM – OPHTHALMIC ANTI-INFECTIVES (STERILE, COMPOUNDED TO ORDER) (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

ANTIBIOTIC EYEDROPS (5 mL unless stated) – see also Fortified Anti-Infective Eye Drops form (select one formula) QUANTITY

☐ OPH-VAN Vancomycin 25 mg/mL (fortified)	QTY: ☐ 5 ☐ 10 mL
☐ OPH-TOB Tobramycin 15 mg/mL (fortified)	QTY: ☐ 5 ☐ 10 mL
☐ OPH-GEN Gentamicin 13.6 mg/mL (fortified)	QTY: ☐ 5 ☐ 10 mL
☐ OPH-CFZ Cefazolin 50 mg/mL	QTY: ☐ 5 ☐ 10 mL
☐ OPH-CTZ Ceftazidime 50 mg/mL	QTY: ☐ 5 ☐ 10 mL
☐ OPH-CTX Ceftriaxone 50 mg/mL	QTY: ☐ 5 ☐ 10 mL
☐ OPH-CFX Cefuroxime 50 mg/mL	QTY: ☐ 5 ☐ 10 mL
☐ OPH-AMK Amikacin 25 mg/mL / 50 mg/mL (circle)	QTY: ☐ 5 ☐ 10 mL
☐ OPH-OXA Oxacillin 66 mg/mL	QTY: ☐ 5 ☐ 10 mL
☐ OPH-PEN Penicillin G potassium 100,000 u/mL / 333,000 u/mL (circle)	QTY: ☐ 5 ☐ 10 mL
☐ OPH-POL Polymyxin B 1 mg/mL / 5 mg/mL (circle)	QTY: ☐ 5 ☐ 10 mL
☐ OPH-COL Colistimethate 50 mg/mL	QTY: ☐ 5 ☐ 10 mL
☐ OPH-BAC Bacitracin 10,000 u/mL	QTY: ☐ 5 ☐ 10 mL

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

☐ _____	QTY: _____ mL
--------------------------------	---------------

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Instill 1 drop in the affected eye(s) every hour while awake for _____ days, then taper as directed.
☐ Instill 1 drop in the affected eye(s) _____ times daily.
☐ Other _____
☐ 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 – OPHTHALMIC ANTI-INFECTIVES (STERILE, COMPOUNDED TO ORDER) (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

ANTIFUNGAL EYE DROPS (select one formula)	QUANTITY
☐ OPH-AMB Amphotericin B 2 / 3 / 5 mg/mL preservative-free (circle)	QTY: ☐ 5 ☐ 10 mL
☐ OPH-VOR Voriconazole 1% / 2% (circle)	QTY: ☐ 5 ☐ 10 mL
☐ OPH-FLU Fluconazole 2 mg/mL	QTY: ☐ 5 ☐ 10 mL
☐ OPH-NAT Natamycin 5% suspension	QTY: ☐ 5 ☐ 10 mL
CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ mL
REFILLS (circle one)	
1 2 3 4 5 6 7 8 9 10 PRN NR	
DIRECTIONS/SIG + SIGNATURE	
☐ Instill 1 drop in the affected eye(s) every hour while awake for _____ days, then taper as directed.	
☐ Instill 1 drop in the affected eye(s) _____ times daily.	
☐ Other _____	
☐ 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 – OPHTHALMIC – OTHER PREPARATIONS

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

MUCOLYTIC / LUBRICANT / IMMUNOMODULATOR (select one formula)	QUANTITY
☐ OPH-NAC10 Acetylcysteine 10% (preserved, multi-dose)	QTY: ☐ 5 ☐ 10 ☐ 15 mL
☐ OPH-NAC5 Acetylcysteine 5%	QTY: ☐ 5 ☐ 10 ☐ 15 mL
☐ OPH-NAC20 Acetylcysteine 20%	QTY: ☐ 5 ☐ 10 ☐ 15 mL
☐ OPH-CSA Cyclosporine 1% / 2% in oil (circle)	QTY: ☐ 5 ☐ 10 ☐ 15 mL
☐ OPH-TAC Tacrolimus 0.03% in oil	QTY: ☐ 5 ☐ 10 ☐ 15 mL
☐ OPH-DDAVP Desmopressin 0.01%	QTY: ☐ 5 ☐ 10 ☐ 15 mL
ANTI-INFLAMMATORY / HORMONAL (select one formula)	QUANTITY
☐ OPH-HC Hydrocortisone 25 mg/mL preservative-free	QTY: ☐ 5 ☐ 10 mL
☐ OPH-MP Methylprednisolone 1%	QTY: ☐ 5 ☐ 10 mL
☐ OPH-MPA Medroxyprogesterone 10 mg/mL suspension	QTY: ☐ 5 ☐ 10 mL
☐ OPH-DEX Dexamethasone 0.4% (4 mg/mL) solution	QTY: ☐ 5 ☐ 10 mL
MYOPIA CONTROL – see Low-Dose Atropine form (select one formula)	QUANTITY
☐ OPH-ATR Atropine 0.01% / 0.02% / 0.05% (circle)	QTY: ☐ 5 ☐ 10 mL
CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____ QTY: _____ mL	

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Instill 1 drop in the affected eye(s) 4 times daily.
☐ Instill 1 drop in both eyes at bedtime.
☐ Instill 1–2 drops in the affected eye(s) every 4 hours as directed. Discard 28 days after opening.
☐ 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