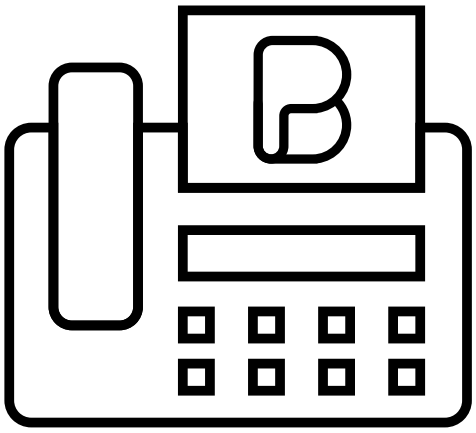
Bayview Pharmacy

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
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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 – VETERINARY COMPOUNDS (1 OF 2)

1 Patient Information

Last Name	First Name			MI
Address				Apt. #
City	State	ZIP	Phone Number	
Pet Name	Species	Breed	Weight (lb/kg)	Pet DOB / Age
Owner Name (if different)		Owner Email		

2 Prescriber Information

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

3 Medication Selection

METHIMAZOLE (feline hyperthyroidism) – flavor: chicken / fish / tuna (select one)	QUANTITY
☐ VET-MET5 Methimazole 5 mg/mL flavored oral suspension	QTY: ☐ 15 ☐ 30 ☐ 60 mL
☐ VET-MET10 Methimazole 10 mg/mL flavored oral suspension	QTY: ☐ 15 ☐ 30 ☐ 60 mL
☐ VET-METT25 Methimazole 2.5 mg / 0.1 mL transdermal ear gel	QTY: ☐ 15 ☐ 30 ☐ 60 mL
☐ VET-METT5 Methimazole 5 mg / 0.1 mL transdermal ear gel	QTY: ☐ 15 ☐ 30 ☐ 60 mL
☐ VET-METTC Methimazole ____ mg / 0.1 mL transdermal ear gel (1.25–10 mg)	QTY: ☐ 15 ☐ 30 ☐ 60 mL

CISAPRIDE / PIMOBENDAN / TRILOSTANE / URSODIOL (select one)	QUANTITY
☐ VET-CIS5 Cisapride 5 mg/mL flavored oral suspension	QTY: ☐ 30 ☐ 60 mL/caps
☐ VET-CISC Cisapride ____ mg capsules	QTY: ☐ 30 ☐ 60 mL/caps
☐ VET-PIM Pimobendan 1.25 / 2.5 / 3 mg/mL flavored oral suspension (circle)	QTY: ☐ 30 ☐ 60 mL/caps
☐ VET-PIMC Pimobendan ____ mg capsules	QTY: ☐ 30 ☐ 60 mL/caps
☐ VET-TRI Trilostane ____ mg capsules (custom strength)	QTY: ☐ 30 ☐ 60 mL/caps
☐ VET-URS Ursodiol 100 mg/mL flavored oral suspension	QTY: ☐ 30 ☐ 60 mL/caps

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

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Give _____ mL by mouth every _____ hours with food.

☐ Apply _____ click(s) to the inner ear pinna every 12 hours, alternating ears; wear gloves.

☐ Give _____ capsule(s) by mouth once daily with food.

☐ 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 – VETERINARY COMPOUNDS (2 OF 2)

1 Patient Information

Last Name	First Name			MI
Address				Apt. #
City	State	ZIP	Phone Number	
Pet Name	Species	Breed	Weight (lb/kg)	Pet DOB / Age
Owner Name (if different)		Owner Email		

2 Prescriber Information

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

3 Medication Selection

OTHER VETERINARY (select one)	QUANTITY
☐ VET-GAB Gabapentin ____ mg/mL flavored oral suspension	QTY: ☐ 30 ☐ 60 mL
☐ VET-ATEN Atenolol 6.25 mg / 0.1 mL transdermal gel	QTY: ☐ 30 ☐ 60 mL
☐ VET-BUD Budesonide 1 mg/mL oral suspension or 1 mg capsules (circle)	QTY: ☐ 30 ☐ 60 mL
☐ VET-PRED Prednisolone 7 mg / 0.1 mL transdermal gel	QTY: ☐ 30 ☐ 60 mL
☐ VET-KCIT Potassium citrate 500 mg/mL oral solution	QTY: ☐ 30 ☐ 60 mL
☐ VET-TRAZ Trazodone 100 mg/mL flavored oral suspension	QTY: ☐ 30 ☐ 60 mL
☐ VET-LEV Levetiracetam 100 mg/mL oral suspension	QTY: ☐ 30 ☐ 60 mL
☐ VET-PPA Phenylpropanolamine 50 mg/mL oral suspension	QTY: ☐ 30 ☐ 60 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

☐ Give _____ mL by mouth every _____ hours with food.

☐ Apply _____ click(s) to the inner ear pinna every 12 hours, alternating ears; wear gloves.

☐ Give _____ capsule(s) by mouth once daily with food.

☐ 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