



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.™

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 - PROGESTERONE

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

PROGESTERONE - Slow-Release Oral Capsules (swallowed)		QUANTITY
☐ PRG-SR100 Progesterone 100 mg SR capsule	QTY: ☐ 30 ☐ 60 ☐ 90 ☐ 180 caps	
☐ PRG-SR200 Progesterone 200 mg SR capsule	QTY: ☐ 30 ☐ 60 ☐ 90 ☐ 180 caps	
PROGESTERONE - Troches & Rapid Dissolve (dissolved in the mouth)		QUANTITY
☐ PRG-TR100 Progesterone 100 mg troche	QTY: ☐ 30 ☐ 60 ☐ 90 units	
☐ PRG-TR200 Progesterone 200 mg troche (wetablet)	QTY: ☐ 30 ☐ 60 ☐ 90 units	
☐ PRG-R50 Progesterone 50 mg rapid dissolve tablet	QTY: ☐ 30 ☐ 60 ☐ 90 units	
☐ PRG-R100 Progesterone 100 mg rapid dissolve tablet	QTY: ☐ 30 ☐ 60 ☐ 90 units	
PROGESTERONE - Topical (applied to the skin)		QUANTITY
☐ PRG-C Progesterone cream _____ mg/gm(10-100)	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm	
☐ PRG-G Progesterone anhydrous gel _____ mg/gm(10-100)	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm	
CUSTOM - (other strength, base or form - call pharmacy to confirm)		QUANTITY
☐ _____	QTY: _____ units	
REFILLS (circle one)		
1 2 3 4 5 6 7 8 9 10 PRN NR		
DIRECTIONS/SIG + SIGNATURE		
☐ Take 1 dose by mouth at bedtime.		
☐ Take 1 dose by mouth at bedtime on days _____ of each cycle.		
☐ Apply _____ gm (or one metered pump) to the skin once daily, rotating sites.		
☐ 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 - BI-EST

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

BI-EST - Topical Cream (estriol / estradiol)		QUANTITY
☐ BE5-C Bi-Est 50/50 cream _____ mg/gm (0.25-2.5)	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm	
☐ BE5-H Bi-Est 50/50 cream _____ mg per 0.5 gm (0.25-1)	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm	
☐ BE8-C Bi-Est 80/20 cream _____ mg/gm (0.25-2.5)	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm	
BI-EST - Anhydrous Gel		QUANTITY
☐ BE5-G Bi-Est 50/50 gel _____ mg/gm (0.25-5)	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm	
☐ BE8-G Bi-Est 80/20 gel 1 mg/gm	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm	
BI-EST - Troches		QUANTITY
☐ BE5-TR Bi-Est 50/50 troche 1 mg	QTY: ☐ 30 ☐ 60 ☐ 90 units	
☐ BE8-TR Bi-Est 80/20 troche 1.25 mg	QTY: ☐ 30 ☐ 60 ☐ 90 units	
CUSTOM - (other strength, base or form - 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 _____ gm (or one metered pump) to the skin once daily, rotating sites.		
☐ Dissolve 1 troche in the mouth once 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 - BI-EST + PROGESTERONE

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

BI-EST + PROGESTERONE - Topical Cream		QUANTITY
☐ BEP5-C 50/50 cream: Bi-Est _____ mg + progesterone _____ mg per gm	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm	
☐ BEP8-C 80/20 cream: Bi-Est _____ mg + progesterone _____ mg per gm	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm	
☐ BEP8-SYR 80/20: Bi-Est 0.1 mg + progesterone 10 mg per 0.1 mL	QTY: _____ syringes	
BI-EST + PROGESTERONE - Anhydrous Gel		QUANTITY
☐ BEP5-G 50/50 gel: Bi-Est 2 mg + progesterone 100 mg per gm	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm	
☐ BEP8-G 80/20 gel: Bi-Est 2.5 mg + progesterone 100 mg per gm	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm	
BI-EST + PROGESTERONE - Troches		QUANTITY
☐ BEP5-TR 50/50 troche: Bi-Est 1 mg + progesterone 50 mg	QTY: ☐ 30 ☐ 60 ☐ 90 units	
☐ BEP8-TR 80/20 troche: Bi-Est 1.25 mg + progesterone 100 mg	QTY: ☐ 30 ☐ 60 ☐ 90 units	
CUSTOM - (other strength, base or form - 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 _____ gm (or one metered pump) to the skin once daily, rotating sites.		
☐ Dissolve 1 troche in the mouth once 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 - ESTRADIOL TOPICAL

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

ESTRADIOL - Topical Cream (VersaBase, rubbed into the skin once daily)		QUANTITY
☐ E2C-05 Estradiol cream 0.5 mg/gm	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm	
☐ E2C-1 Estradiol cream 1 mg/gm	QTY: ☐ 30 ☐ 60 ☐ 90 gm	
☐ E2C-15 Estradiol cream 1.5 mg/gm	QTY: ☐ 90 ☐ 180 gm	
☐ E2C-2 Estradiol cream 2 mg/gm	QTY: ☐ 30 ☐ 90 gm	
☐ E2C-4 Estradiol cream 4 mg/gm	QTY: ☐ 90 gm	
ESTRADIOL - Prefilled Syringes		QUANTITY
☐ E2C-SYR Estradiol 1 mg / 0.1 mL prefilled syringes	QTY: ☐ 9 syringes (27 gm)	
CUSTOM - (other strength, base or form - 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 _____ gm (or one measured syringe) to the skin once daily, rotating sites, or as directed.		
☐ 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 - DHEA

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

DHEA - Oral Capsules		QUANTITY
☐ DHE-CAP DHEA capsule _____ mg (5-50)	QTY: ☐ 30 ☐ 60 ☐ 90 caps	
DHEA - Vaginal Ovules		QUANTITY
☐ DHE-OV DHEA vaginal ovule _____ mg (3.25-6.5)	QTY: _____ ovules	
DHEA - Topical (strength to prescriber order)		QUANTITY
☐ DHE-C DHEA topical cream _____ mg/gm	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm	
☐ DHE-G DHEA topical gel _____ mg/gm	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm	
CUSTOM - (other strength, base or form - call pharmacy to confirm)		QUANTITY
☐ _____	QTY: _____ units	
REFILLS (circle one)		
1 2 3 4 5 6 7 8 9 10 PRN NR		
DIRECTIONS/SIG + SIGNATURE		
☐ Take 1 dose by mouth at bedtime.		
☐ Insert 1 ovule vaginally at bedtime, or as directed.		
☐ Apply _____ gm (or one metered pump) to the skin once daily, rotating sites.		
☐ 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