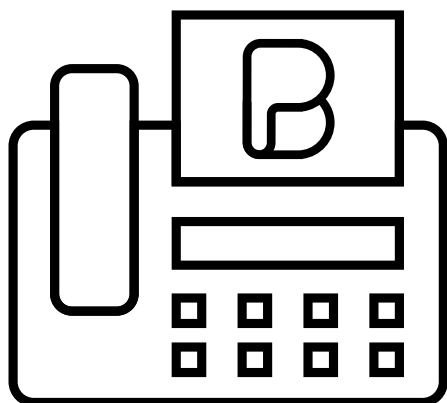




Your modern compounding pharmacy.™

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
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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.

3844 Post Road, Warwick RI 02886
Phone: 401-284-4505
Fax: 401-284-4506
Alternate Fax: 401-210-2757
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NEW PRESCRIPTION ORDER FORM – MELASMA & DARK SPOTS

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

MELASMA & HYPERPIGMENTATION – Topical Gel or Cream (select one formula)	QUANTITY
☐ MEL-HKT Hydroquinone 8% / kojic acid 6% / tranexamic acid 3% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ MEL-HHKNT Hydroquinone 12% / hydrocortisone 1% / kojic acid 6% / niacinamide 2% / tretinoin 0.05% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ MEL-HHKN Hydroquinone 12% / hydrocortisone 1% / kojic acid 6% / niacinamide 2% gel (tretinoin-free)	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ MEL-HANK Hydroquinone 4% / azelaic acid 10% / niacinamide 4% / kojic acid 2% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ MEL-HQ6 Hydroquinone 6% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ MEL-HQ4T Hydroquinone 4% / tretinoin 0.025% / hydrocortisone 1% cream (modified Kligman)	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ MEL-TXA10 Tranexamic acid 10% cream	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ MEL-ATS Azelaic acid 10% / tretinoin 0.0125% / salicylic acid 5% cream	QTY: ☐ 30 ☐ 45 ☐ 60 gm

Hydroquinone courses are usually limited to 8–12 weeks, then a hydroquinone-free maintenance formula.

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 a pea-sized amount to the affected area(s) nightly.
☐ Apply to dark spots only, once daily; use sunscreen every morning.
☐ Start 2–3 nights per week and increase as tolerated.
☐ 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-RI-CR-40-15-1 section 1.3A10

Pharmacy Fax Number

NEW PRESCRIPTION ORDER FORM – WRINKLES & FINE LINES

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

ANTI-AGING – Tretinoin / Niacinamide / Sodium Hyaluronate Gel (select one formula)	QUANTITY
☐ WRK-T01 Tretinoin 0.01% / niacinamide 2% / sodium hyaluronate 0.05% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ WRK-T025 Tretinoin 0.025% / niacinamide 2% / sodium hyaluronate 0.05% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ WRK-T05 Tretinoin 0.05% / niacinamide 2% / sodium hyaluronate 0.05% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ WRK-T1 Tretinoin 0.1% / niacinamide 2% / sodium hyaluronate 0.05% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
SCARS & STRETCH MARKS – Topical Gel (select one formula)	QUANTITY
☐ SCR-TRE Tretinoin 0.1% gel	QTY: ☐ 30 ☐ 60 gm
☐ SCR-TOP Topiramate 2.5% / aloe vera 0.5% gel	QTY: ☐ 30 ☐ 60 gm
☐ SCR-SIL Tretinoin 0.05% / sodium hyaluronate 0.5% silicone scar gel	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	
☐ Apply a pea-sized amount to the entire face nightly.	
☐ Start 2-3 nights per week and increase to nightly as tolerated.	
☐ Apply a thin layer to the scar/stretch marks twice 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-RCR-40-15-1 section 1.3A10

Pharmacy Fax Number