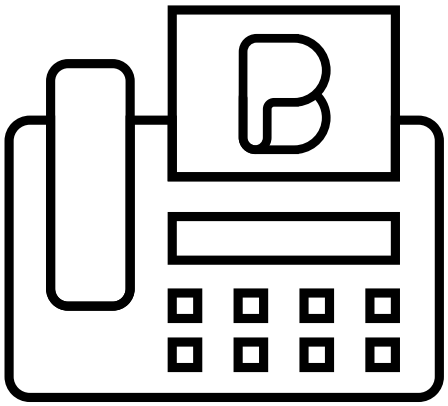
Bayview Pharmacy

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
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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.

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Phone: 401-284-4505
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NEW PRESCRIPTION ORDER FORM – SINUS IRRIGATION & NASAL SPRAYS (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

SINUS IRRIGATION CAPSULES (dissolve 1 capsule in 240 mL saline rinse) (select one formula)	QUANTITY
☐ SNS-BUD06 Budesonide 0.6 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-BUD1 Budesonide 1 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-MOM Mometasone 0.6 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-MUP Mupirocin 15 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-GEN Gentamicin 80 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-VAN Vancomycin 200 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-LEV Levofloxacin 100 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-CLI Clindamycin 50 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-AMB Amphotericin B 5 mg / 10 mg capsule (circle)	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-ITR Itraconazole 40 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-BIO Mupirocin 30 mg / edetate disodium 15 mg / gentamicin 80 mg capsule (biofilm)	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-BUDABX Budesonide 0.6 mg + _____ ____ mg combination capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
Capsules can also be nebulized: dissolve 1 capsule in 15 mL saline and nebulize into both nostrils twice daily.	

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

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

- ☐ Dissolve contents of 1 capsule in 240 mL saline; irrigate half per nostril twice daily.
- ☐ Spray once in each nostril twice daily.
- ☐ Spray _____ time(s) in each nostril _____ times daily as needed.
- ☐ 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 – SINUS IRRIGATION & NASAL SPRAYS (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

NASAL SPRAYS (select one formula)	QUANTITY
☐ NAS-MUP Mupirocin 0.2% nasal spray	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ NAS-LID4 Lidocaine 4% nasal spray (headache / procedures)	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ NAS-KET Ketoconazole 2% nasal spray	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ NAS-GLU Glutathione 125 mg/mL nasal spray	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ NAS-IVM Ivermectin 1 mg / 0.1 mL nasal spray	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ NAS-BIO Gentamicin 0.008% / mupirocin 0.2% / edetate disodium 0.1% nasal spray (biofilm)	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ NAS-TXA Tranexamic acid 5% / 10% nasal spray (nosebleeds, circle)	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ NAS-CM Camphor 0.2% / menthol 0.2% in mineral oil nasal spray (dryness)	QTY: ☐ 10 ☐ 15 ☐ 30 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

- ☐ Dissolve contents of 1 capsule in 240 mL saline; irrigate half per nostril twice daily.
- ☐ Spray once in each nostril twice daily.
- ☐ Spray _____ time(s) in each nostril _____ times daily as needed.
- ☐ 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

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NEW PRESCRIPTION ORDER FORM – EAR, THROAT & MOUTH (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

OTIC SOLUTIONS (select one formula)	QUANTITY
☐ OTC-BNZ10 Benzocaine 10% otic solution	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ OTC-BNZ20 Benzocaine 20% otic solution	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ OTC-TET30 Tetracaine 30% otic solution	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ OTC-DOC Docusate sodium 2% otic solution (ear wax softening)	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ OTC-TRO Trolamine oleate otic solution (ear wax softening)	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ OTC-VAN Vancomycin 25 mg/mL otic solution	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ OTC-TAC Tacrolimus 0.1% otic solution	QTY: ☐ 10 ☐ 15 ☐ 30 mL

THROAT – Popsicles, Rinses & Lozenges (select one formula)	QUANTITY
☐ THR-TETP Tetracaine 0.025% popsicle	QTY: ☐ 12 ☐ 30 ☐ 240 count/mL
☐ THR-LIDP Lidocaine 2% popsicle	QTY: ☐ 12 ☐ 30 ☐ 240 count/mL
☐ THR-IBUP Ibuprofen 100 mg popsicle	QTY: ☐ 12 ☐ 30 ☐ 240 count/mL
☐ THR-LIDR Lidocaine 2% oral rinse	QTY: ☐ 12 ☐ 30 ☐ 240 count/mL
☐ THR-MEN Menthol 0.3% oral solution (instant voice)	QTY: ☐ 12 ☐ 30 ☐ 240 count/mL
☐ THR-PIL Pilocarpine 10 mg/mL oral solution (dry mouth)	QTY: ☐ 12 ☐ 30 ☐ 240 count/mL
☐ THR-PILL Pilocarpine 2 mg / 4 mg lozenge (dry mouth, circle)	QTY: ☐ 12 ☐ 30 ☐ 240 count/mL

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

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Instill _____ drops in the affected ear _____ times daily.

☐ Place _____ drops under the tongue _____ times daily for excess secretions.

☐ Apply 0.25 mL to the inner wrist every _____ hours as needed.

☐ 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

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NEW PRESCRIPTION ORDER FORM – EAR, THROAT & MOUTH (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

SIALORRHEA (EXCESS SECRETIONS) & NAUSEA (select one formula)	QUANTITY
☐ SIA-ATR Atropine 1% sublingual drops	QTY: ☐ 15 ☐ 30 ☐ 60 mL/gm/count
☐ SIA-GLYS Glycopyrrolate 0.5 mg/mL oral suspension	QTY: ☐ 15 ☐ 30 ☐ 60 mL/gm/count
☐ SIA-GLYT Glycopyrrolate 0.1 mg / 0.25 mL topical cream	QTY: ☐ 15 ☐ 30 ☐ 60 mL/gm/count
☐ SIA-SCO Scopolamine 0.25 mg / 0.1 mL topical cream	QTY: ☐ 15 ☐ 30 ☐ 60 mL/gm/count
☐ NAU-OND Ondansetron 4 mg / 0.1 mL topical cream	QTY: ☐ 15 ☐ 30 ☐ 60 mL/gm/count
☐ NAU-PRO Promethazine 25 mg/g topical cream	QTY: ☐ 15 ☐ 30 ☐ 60 mL/gm/count
☐ NAU-DPS Doxylamine 10 mg / pyridoxine 10 mg suppository	QTY: ☐ 15 ☐ 30 ☐ 60 mL/gm/count
☐ NAU-DPG Doxylamine 10 mg / pyridoxine 10 mg / ginger root capsule	QTY: ☐ 15 ☐ 30 ☐ 60 mL/gm/count

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

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

- ☐ Instill _____ drops in the affected ear _____ times daily.
- ☐ Place _____ drops under the tongue _____ times daily for excess secretions.
- ☐ Apply 0.25 mL to the inner wrist every _____ hours as needed.
- ☐ Other _____

X _____ _____

Prescriber's Signature Date

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_____ _____

Pharmacy Name Pharmacy Fax Number

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