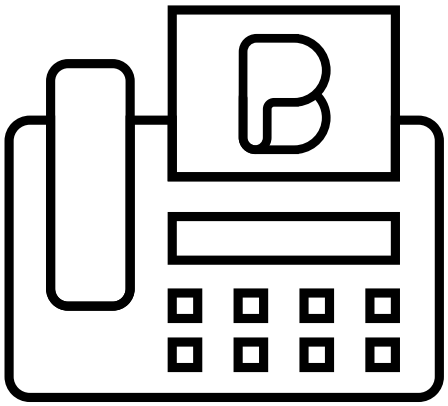
Bayview Pharmacy

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
www.bayviewrx.com

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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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Fax: 401-284-4506
Alternate Fax: 401-210-2757
www.bayviewrx.com

NEW PRESCRIPTION ORDER FORM – HEMORRHOIDS & ANAL FISSURES

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

ANAL FISSURES – Rectal Ointment (see also Anorectal Topicals form) (select one formula)	QUANTITY
☐ FIS-DL Diltiazem 2% / lidocaine 3% ointment	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count
☐ FIS-DL5 Diltiazem 2% / lidocaine 5% ointment	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count
☐ FIS-DLH Diltiazem 2% / lidocaine 2.5% / hydrocortisone 2.5% ointment	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count
☐ FIS-NL15 Nifedipine 0.3% / lidocaine 1.5% ointment	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count
☐ FIS-NL2 Nifedipine 0.2% / lidocaine 2% ointment	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count
☐ FIS-NTGL Nitroglycerin 0.125% / lidocaine 1% ointment	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count
☐ FIS-BD Bethanechol 0.1% / diltiazem 2% ointment	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count
☐ FIS-NS Nifedipine 0.2% suppository	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count
☐ FIS-DHL Diltiazem 3% / hydrocortisone 1% / lidocaine 2% suppository	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count

Do not combine nitroglycerin with sildenafil, tadalafil or vardenafil.

HEMORRHOIDS – Ointment or Suppository (select one formula)	QUANTITY
☐ HEM-HL3S Hydrocortisone 2% / lidocaine 3% rectal rocket suppository	QTY: ☐ 30 ☐ 60 ☐ 5 gm/count
☐ HEM-HL1 Hydrocortisone 2% / lidocaine 1% ointment	QTY: ☐ 30 ☐ 60 ☐ 5 gm/count
☐ HEM-PZL Pramoxine 1% / zinc oxide 10.5% / lidocaine 5% ointment	QTY: ☐ 30 ☐ 60 ☐ 5 gm/count
☐ HEM-HL2S Hydrocortisone 1% / lidocaine 2% rectal rocket suppository	QTY: ☐ 30 ☐ 60 ☐ 5 gm/count

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

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 anal area 2–3 times daily and after bowel movements.
- ☐ Insert 1 suppository rectally at bedtime for 5 nights.
- ☐ Apply a small amount into the rectum every 12 hours for up to 8 weeks.
- ☐ 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

The pharmacy name & fax # cannot be pre-printed in order to comply with RI Law 216-RICR-40-15-1 section 1.3A10

NEW PRESCRIPTION ORDER FORM – RECTAL SPASM, PELVIC FLOOR & SKIN

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

RECTAL / ANAL SPASM & PELVIC FLOOR – Suppository or Ointment (select one formula)	QUANTITY
☐ SPM-BGC Baclofen 20 mg / guaifenesin 50 mg / cyclobenzaprine 20 mg suppository	QTY: ☐ 15 ☐ 30 count
☐ SPM-BGCO Baclofen 2% / guaifenesin 5% / cyclobenzaprine 2% ointment	QTY: ☐ 15 ☐ 30 count
☐ SPM-BL Baclofen 10 mg / lidocaine 5% suppository (pelvic floor dysfunction)	QTY: ☐ 15 ☐ 30 count
☐ SPM-B10 Baclofen 10 mg suppository (vaginal or rectal)	QTY: ☐ 15 ☐ 30 count
☐ SPM-DB Diazepam 5 mg / baclofen 10 mg suppository (Schedule IV - EPCS only)	QTY: ☐ 15 ☐ 30 count
☐ SPM-D5 Diazepam 5 mg suppository (Schedule IV - EPCS only)	QTY: ☐ 15 ☐ 30 count
PERIANAL SKIN IRRITATION – Ointment (select one formula)	**QUANTITY**
☐ SKN-CHOL Cholestyramine 10% ointment	QTY: ☐ 30 ☐ 60 ☐ 120 gm
☐ SKN-CMM Cholestyramine 5% / mupirocin 0.5% / miconazole 0.5% ointment	QTY: ☐ 30 ☐ 60 ☐ 120 gm
☐ SKN-ZNC Zinc oxide 20% / nystatin 100,000 u/g / hydrocortisone 1% barrier cream	QTY: ☐ 30 ☐ 60 ☐ 120 gm
☐ SKN-MET Metronidazole 10% ointment (post-surgical)	QTY: ☐ 30 ☐ 60 ☐ 120 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

- ☐ Insert 1 suppository rectally at bedtime as needed for spasm.
- ☐ Apply a pea-sized amount to the anal area 2–3 times daily.
- ☐ Apply a thin layer to the affected skin after each bowel movement.
- ☐ 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 – IBD, PROCTITIS & COLITIS (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

RECTAL – Enemas (60 mL) (select one formula)	QUANTITY
☐ IBD-BUD2E Budesonide 2 mg / 60 mL enema	QTY: ☐ 14 ☐ 30 enemas
☐ IBD-MBE Mesalamine 4 g / budesonide 2 mg per 60 mL enema	QTY: ☐ 14 ☐ 30 enemas
☐ IBD-BBE Budesonide 1 mg / sodium butyrate 100 mM per 60 mL enema	QTY: ☐ 14 ☐ 30 enemas
☐ IBD-SBE Sodium butyrate 100 mM enema	QTY: ☐ 14 ☐ 30 enemas
☐ IBD-SCFA Short-chain fatty acid (acetate/propionate/butyrate 60/30/40 mM) enema	QTY: ☐ 14 ☐ 30 enemas
☐ IBD-SUC Sucralfate 40 mg/mL enema (radiation proctitis)	QTY: ☐ 14 ☐ 30 enemas
☐ IBD-TAC Tacrolimus 4 mg / 60 mL enema (resistant proctitis)	QTY: ☐ 14 ☐ 30 enemas
☐ IBD-VME Vancomycin 500 mg / metronidazole 250 mg per 60 mL enema (C. difficile)	QTY: ☐ 14 ☐ 30 enemas

RECTAL – Suppositories & Ointment (select one formula)	QUANTITY
☐ IBD-BUDS Budesonide 2 mg / 4 mg suppository (circle)	QTY: ☐ 14 ☐ 30 ☐ 60 count/gm
☐ IBD-MESS Mesalamine 250 / 500 / 750 / 900 mg suppository (circle)	QTY: ☐ 14 ☐ 30 ☐ 60 count/gm
☐ IBD-SBS Sodium butyrate 264 mg suppository	QTY: ☐ 14 ☐ 30 ☐ 60 count/gm
☐ IBD-TACS Tacrolimus 2 mg suppository	QTY: ☐ 14 ☐ 30 ☐ 60 count/gm
☐ IBD-TACO Tacrolimus 0.1% rectal ointment	QTY: ☐ 14 ☐ 30 ☐ 60 count/gm

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

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Administer one enema rectally at bedtime and retain overnight for _____ weeks.

☐ Insert 1 suppository rectally _____ times daily.

☐ Take _____ mL by mouth twice daily, slowly; nothing to eat or drink for 30 minutes after.

☐ 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 – IBD, PROCTITIS & COLITIS (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

ORAL (select one formula)	QUANTITY
☐ IBD-BUD1 Budesonide 1 mg / 10 mL oral suspension	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ IBD-BUDG Budesonide 2 mg / 10 mL oral viscous gel	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ IBD-MESL Mesalamine 50 mg/mL oral liquid	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ IBD-LDN Low dose naltrexone 1.5 / 3 / 4.5 mg capsule (circle)	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ IBD-VAN Vancomycin 20 mg/mL oral solution (C. difficile) - flavor: _____	QTY: ☐ 30 ☐ 90 ☐ 240 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

☐ Administer one enema rectally at bedtime and retain overnight for _____ weeks.

☐ Insert 1 suppository rectally _____ times daily.

☐ Take _____ mL by mouth twice daily, slowly; nothing to eat or drink for 30 minutes after.

☐ 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 – REFLUX, GASTROPARESIS & EOSINOPHILIC ESOPHAGITIS (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

REFLUX – PPI Oral Suspensions (flavor: cherry / strawberry / watermelon / banana / flavorless) (select one formula)	QUANTITY
☐ RFX-OME Omeprazole ____ mg/mL oral suspension (2 - 10 mg/mL)	QTY: ☐ 90 ☐ 150 ☐ 300 mL
☐ RFX-ESO Esomeprazole 2 mg/mL oral suspension	QTY: ☐ 90 ☐ 150 ☐ 300 mL
☐ RFX-LAN Lansoprazole ____ mg/mL oral suspension (3 - 10 mg/mL)	QTY: ☐ 90 ☐ 150 ☐ 300 mL
☐ RFX-PAN Pantoprazole 2 mg/mL or 4 mg/mL oral suspension (circle)	QTY: ☐ 90 ☐ 150 ☐ 300 mL
EOSINOPHILIC ESOPHAGITIS / COLITIS – Oral Suspension (select one formula)	**QUANTITY**
☐ EOE-BUD1 Budesonide 1 mg / 5 mL oral viscous suspension	QTY: ☐ 150 ☐ 300 mL
☐ EOE-BUD2 Budesonide 2 mg / 5 mL oral viscous suspension	QTY: ☐ 150 ☐ 300 mL
☐ EOE-MKB Montelukast 1 mg/mL / ketotifen 0.5 mg/mL / budesonide 0.5 mg/mL oral suspension	QTY: ☐ 150 ☐ 300 mL
☐ EOE-MKBQ Montelukast 1 mg/mL / ketotifen 0.5 mg/mL / budesonide 0.5 mg/mL / quercetin 10 mg/mL oral suspension	QTY: ☐ 150 ☐ 300 mL
☐ EOE-FLU Fluticasone 3 mg / 5 mL oral viscous suspension	QTY: ☐ 150 ☐ 300 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

☐ Take _____ mL by mouth _____ times daily.

☐ Take 5 mL by mouth twice daily; swallow slowly and do not eat or drink for 30 minutes after.

☐ Take 1 capsule by mouth at bedtime.

☐ 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 – REFLUX, GASTROPARESIS & EOSINOPHILIC ESOPHAGITIS (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

GASTROPARESIS / IBS – Capsules (select one formula)	QUANTITY
☐ GAS-N15 Naltrexone 1.5 mg capsule	QTY: ☐ 30 ☐ 90 caps
☐ GAS-N45 Naltrexone 4.5 mg capsule	QTY: ☐ 30 ☐ 90 caps
☐ GAS-N05 Naltrexone 0.5 mg capsule (IBS)	QTY: ☐ 30 ☐ 90 caps
☐ GAS-CIS Cisapride 5 mg/mL oral suspension (human use - call pharmacy)	QTY: ☐ 30 ☐ 90 caps

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

☐ Take _____ mL by mouth _____ times daily.

☐ Take 5 mL by mouth twice daily; swallow slowly and do not eat or drink for 30 minutes after.

☐ Take 1 capsule by mouth at bedtime.

☐ 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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