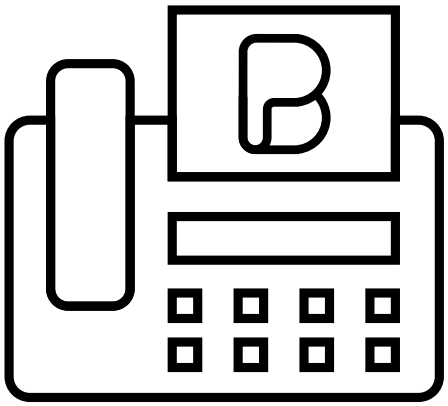
Bayview Pharmacy

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

Bayview Pharmacy

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 – OPHTHALMIC ANTI-INFECTIVES (STERILE, COMPOUNDED TO ORDER) (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

ANTIBIOTIC EYE DROPS (5 mL unless stated) – see also Fortified Anti-Infective Eye Drops form (select one formula)	QUANTITY
☐ OPH-VAN Vancomycin 25 mg/mL (fortified)	QTY: ☐ 5 ☐ 10 mL
☐ OPH-TOB Tobramycin 15 mg/mL (fortified)	QTY: ☐ 5 ☐ 10 mL
☐ OPH-GEN Gentamicin 13.6 mg/mL (fortified)	QTY: ☐ 5 ☐ 10 mL
☐ OPH-CFZ Cefazolin 50 mg/mL	QTY: ☐ 5 ☐ 10 mL
☐ OPH-CTZ Ceftazidime 50 mg/mL	QTY: ☐ 5 ☐ 10 mL
☐ OPH-CTX Ceftriaxone 50 mg/mL	QTY: ☐ 5 ☐ 10 mL
☐ OPH-CFX Cefuroxime 50 mg/mL	QTY: ☐ 5 ☐ 10 mL
☐ OPH-AMK Amikacin 25 mg/mL / 50 mg/mL (circle)	QTY: ☐ 5 ☐ 10 mL
☐ OPH-OXA Oxacillin 66 mg/mL	QTY: ☐ 5 ☐ 10 mL
☐ OPH-PEN Penicillin G potassium 100,000 u/mL / 333,000 u/mL (circle)	QTY: ☐ 5 ☐ 10 mL
☐ OPH-POL Polymyxin B 1 mg/mL / 5 mg/mL (circle)	QTY: ☐ 5 ☐ 10 mL
☐ OPH-COL Colistimethate 50 mg/mL	QTY: ☐ 5 ☐ 10 mL
☐ OPH-BAC Bacitracin 10,000 u/mL	QTY: ☐ 5 ☐ 10 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

☐ Instill 1 drop in the affected eye(s) every hour while awake for _____ days, then taper as directed.

☐ Instill 1 drop in the affected eye(s) _____ times daily.

☐ Other

☐ 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 – OPHTHALMIC ANTI-INFECTIVES (STERILE, COMPOUNDED TO ORDER) (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

ANTIFUNGAL EYE DROPS (select one formula)	QUANTITY
☐ OPH-AMB Amphotericin B 2 / 3 / 5 mg/mL preservative-free (circle)	QTY: ☐ 5 ☐ 10 mL
☐ OPH-VOR Voriconazole 1% / 2% (circle)	QTY: ☐ 5 ☐ 10 mL
☐ OPH-FLU Fluconazole 2 mg/mL	QTY: ☐ 5 ☐ 10 mL
☐ OPH-NAT Natamycin 5% suspension	QTY: ☐ 5 ☐ 10 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

- ☐ Instill 1 drop in the affected eye(s) every hour while awake for _____ days, then taper as directed.
- ☐ Instill 1 drop in the affected eye(s) _____ times daily.
- ☐ Other
- ☐ 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 – OPHTHALMIC – OTHER PREPARATIONS

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

MUCOLYTIC / LUBRICANT / IMMUNOMODULATOR (select one formula)	QUANTITY
☐ OPH-NAC10 Acetylcysteine 10% (preserved, multi-dose)	QTY: ☐ 5 ☐ 10 ☐ 15 mL
☐ OPH-NAC5 Acetylcysteine 5%	QTY: ☐ 5 ☐ 10 ☐ 15 mL
☐ OPH-NAC20 Acetylcysteine 20%	QTY: ☐ 5 ☐ 10 ☐ 15 mL
☐ OPH-CSA Cyclosporine 1% / 2% in oil (circle)	QTY: ☐ 5 ☐ 10 ☐ 15 mL
☐ OPH-TAC Tacrolimus 0.03% in oil	QTY: ☐ 5 ☐ 10 ☐ 15 mL
☐ OPH-DDAVP Desmopressin 0.01%	QTY: ☐ 5 ☐ 10 ☐ 15 mL
ANTI-INFLAMMATORY / HORMONAL (select one formula)	**QUANTITY**
☐ OPH-HC Hydrocortisone 25 mg/mL preservative-free	QTY: ☐ 5 ☐ 10 mL
☐ OPH-MP Methylprednisolone 1%	QTY: ☐ 5 ☐ 10 mL
☐ OPH-MPA Medroxyprogesterone 10 mg/mL suspension	QTY: ☐ 5 ☐ 10 mL
☐ OPH-DEX Dexamethasone 0.4% (4 mg/mL) solution	QTY: ☐ 5 ☐ 10 mL
MYOPIA CONTROL – see Low-Dose Atropine form (select one formula)	**QUANTITY**
☐ OPH-ATR Atropine 0.01% / 0.02% / 0.05% (circle)	QTY: ☐ 5 ☐ 10 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

- ☐ Instill 1 drop in the affected eye(s) 4 times daily.
- ☐ Instill 1 drop in both eyes at bedtime.
- ☐ Instill 1–2 drops in the affected eye(s) every 4 hours as directed. Discard 28 days after opening.
- ☐ 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