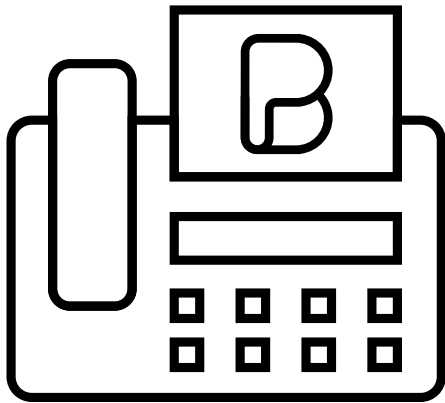




Your modern compounding pharmacy.™

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 – TOPICAL PAIN (INFLAMMATORY, MUSCULAR, NEUROPATHIC) (1 OF 2)

1 Patient Information

Last Name	First Name	MI
Address		Apt. #
City	State	ZIP
Date of Birth (mm/dd/yyyy)		Phone Number
Sex	OM OF	Email

2 Prescriber Information

Prescriber's Name		
Phone Number	Fax Number	
Street Address		
City	State	ZIP
NPI	DEA	

3 Medication Selection

INFLAMMATORY PAIN – Cream or Gel (select one formula)	QUANTITY
☐ TPI-D10 Diclofenac 10%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPI-DL Diclofenac 10% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPI-K10 Ketoprofen 10%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPI-KL Ketoprofen 10% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPI-LK20 Lidocaine 20% / ketoprofen 20% ointment	QTY: ☐ 60 ☐ 120 ☐ 180 gm
INFLAMMATORY & MUSCULAR PAIN (select one formula)	QUANTITY
☐ TPM-CDL Cyclobenzaprine 2% / diclofenac 10% / lidocaine 10%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPM-CKL Cyclobenzaprine 2% / ketoprofen 10% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPM-CDLM Cyclobenzaprine 2% / diclofenac 3% / lidocaine 2% / magnesium chloride 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPM-C2 Cyclobenzaprine 2%	QTY: ☐ 60 ☐ 120 ☐ 180 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 1–2 mL (1–2 pumps) to the affected area 3–4 times daily as needed.
☐ Apply a thin layer to the affected area every 8 hours as needed for pain; do not apply to broken skin.
☐ 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-RCR-40-15-1 section 1.3A10

NEW PRESCRIPTION ORDER FORM – TOPICAL PAIN (INFLAMMATORY, MUSCULAR, NEUROPATHIC) (2 OF 2)

1 Patient Information

Last Name	First Name	MI
Address		Apt. #
City	State	ZIP
Date of Birth (mm/dd/yyyy)		Phone Number
Sex	OM OF	Email

2 Prescriber Information

Prescriber's Name		
Phone Number	Fax Number	
Street Address		
City	State	ZIP
NPI	DEA	

3 Medication Selection

NEUROPATHIC & MIXED PAIN (select one formula)	QUANTITY
☐ TPN-DGL Diclofenac 5% / gabapentin 10% / lidocaine 7%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPN-ADG Amitriptyline 2% / diclofenac 5% / gabapentin 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPN-GKL Gabapentin 10% / ketoprofen 20% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPN-CGKL Cyclobenzaprine 2% / gabapentin 6% / ketoprofen 15% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPN-BGKL Baclofen 2% / gabapentin 6% / ketoprofen 10% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPN-GLB Gabapentin 6% / lidocaine 5% / bupivacaine 2%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPN-G6 Gabapentin 6%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPN-SHN Acyclovir 5% / amitriptyline 2% / bupivacaine 1% / gabapentin 6% / ketoprofen 5% (shingles / post-herpetic)	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ TPN-KAC Ketamine 6% / amitriptyline 4% / cyclobenzaprine 5% (Schedule III - EPCS only)	QTY: ☐ 60 ☐ 120 ☐ 180 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 1–2 mL (1–2 pumps) to the affected area 3–4 times daily as needed.
☐ Apply a thin layer to the affected area every 8 hours as needed for pain; do not apply to broken skin.
☐ 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 – PELVIC & PROCEDURE PAIN

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

PELVIC PAIN – Topical or Rectal (select one formula)	QUANTITY
☐ PLV-IBU20 Ibuprofen 20% cream (external use)	QTY: ☐ 30 ☐ 60 ☐ 12 gm/count
☐ PLV-K10 Ketoprofen 10% cream	QTY: ☐ 30 ☐ 60 ☐ 12 gm/count
☐ PLV-KC Ketoprofen 10% / cyclobenzaprine 2% cream	QTY: ☐ 30 ☐ 60 ☐ 12 gm/count
☐ PLV-IBUS Ibuprofen 600 mg suppository	QTY: ☐ 30 ☐ 60 ☐ 12 gm/count

PROCEDURE / PRE-INJECTION ANESTHETIC – Cream or Gel (select one formula)	QUANTITY
☐ PRA-LT23 Lidocaine 23% / tetracaine 7% plasticized ointment	QTY: ☐ 30 ☐ 60 ☐ 120 gm
☐ PRA-BLT Benzocaine 20% / lidocaine 8% / tetracaine 4% plasticized gel	QTY: ☐ 30 ☐ 60 ☐ 120 gm
☐ PRA-BLT10 Benzocaine 20% / lidocaine 10% / tetracaine 10% gel	QTY: ☐ 30 ☐ 60 ☐ 120 gm
☐ PRA-LP Lidocaine 5% / prilocaine 5% gel	QTY: ☐ 30 ☐ 60 ☐ 120 gm
☐ PRA-L30 Lidocaine 30% plasticized	QTY: ☐ 30 ☐ 60 ☐ 120 gm
☐ PRA-T4 Tetracaine 4% gel	QTY: ☐ 30 ☐ 60 ☐ 120 gm

Also available as the dedicated BLT Numbing Cream order form. High-strength anesthetics are for provider-supervised use on intact skin.

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

OFFICE USE – provider-applied or office-stocked items

Charge to: ☐ Patient ☐ Office Ship to: ☐ Patient ☐ Office ☐ Patient pick-up

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Apply a thin layer to the area 30–45 minutes before the procedure; remove before treatment.

☐ Apply 1–2 mL to the affected area 3 times daily as needed.

☐ Insert 1 suppository rectally every 8 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

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