



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.

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NEW PRESCRIPTION ORDER FORM – HIRSUTISM & PCOS

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

FACIAL HAIR (HIRSUTISM) – Cream or Gel (select one formula)	QUANTITY
☐ HIR-AMPS Azelaic acid 1% / metformin 5% / progesterone 1% / spironolactone 5% facial cream	QTY: ☐ 30 ☐ 60 gm
☐ HIR-AMP Azelaic acid 1% / metformin 5% / progesterone 1% facial cream	QTY: ☐ 30 ☐ 60 gm
☐ HIR-FIN Finasteride 0.25% facial cream	QTY: ☐ 30 ☐ 60 gm
☐ HIR-SPI5 Spironolactone 5% gel	QTY: ☐ 30 ☐ 60 gm
☐ HIR-EFL Eflornithine 13.9% cream	QTY: ☐ 30 ☐ 60 gm
PCOS – Topical & Vaginal (select one formula)	QUANTITY
☐ PCO-MET10 Metformin 10% topical cream or gel	QTY: ☐ 30 ☐ 60 gm
☐ PCO-MET20 Metformin 20% topical gel	QTY: ☐ 30 ☐ 60 gm
☐ PCO-METV Metformin 10% vaginal gel	QTY: ☐ 30 ☐ 60 gm
☐ PCO-PRGV Progesterone 10% vaginal gel	QTY: ☐ 30 ☐ 60 gm
PCOS – Oral (select one formula)	QUANTITY
☐ PCO-PRG100 Progesterone 100 mg slow-release capsule	QTY: ☐ 30 ☐ 90 caps
☐ PCO-PRG200 Progesterone 200 mg slow-release capsule	QTY: ☐ 30 ☐ 90 caps
☐ PCO-MINSP Minoxidil 0.25 mg / spironolactone 25 mg capsule (PCOS hair thinning)	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

☐ Apply a thin layer to the affected area(s) twice daily.
☐ Take 1 capsule by mouth at bedtime on days 14–25 of the cycle.
☐ Take 1 capsule by mouth once 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-RI-CR-40-15-1 section 1.3A10 Pharmacy Fax Number _____