



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 – FOOT PAIN, HEEL SPURS & NEUROPATHY (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

NEUROPATHIC & MIXED FOOT PAIN – Transdermal Cream or Gel (select one formula)	QUANTITY
☐ FTP-ADG Amitriptyline 2% / diclofenac 5% / gabapentin 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ FTP-DGL Diclofenac 5% / gabapentin 10% / lidocaine 7%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ FTP-GKL Gabapentin 10% / ketoprofen 20% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ FTP-KGTB Ketoprofen 10% / gabapentin 10% / tizanidine 0.2% / baclofen 2%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ FTP-KGCN Ketoprofen 10% / gabapentin 6% / clonidine 0.2% / nifedipine 2% (ischemic / neuropathic)	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ FTP-GCB Gabapentin 10% / clonidine 0.2% / baclofen 1% (burning foot)	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ FTP-FAGLP Flurbiprofen 10% / amitriptyline 1% / gabapentin 6% / lidocaine 2% / prilocaine 2%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ FTP-G6 Gabapentin 6%	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.	
☐ 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-RCR-40-15-1 section 1.3A10

Pharmacy Fax Number

NEW PRESCRIPTION ORDER FORM – FOOT PAIN, HEEL SPURS & NEUROPATHY (2 OF 2)

1 Patient Information

Last Name	First Name	MI
Address		Apt. #
City	State	ZIP
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

HEEL SPURS / PLANTAR FASCIITIS / TENDON – Cream or Gel (select one formula)	QUANTITY
☐ HSP-ABK Amitriptyline 2% / baclofen 2% / ketoprofen 10%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ HSP-KTB Ketoprofen 10% / tizanidine 0.2% / bupivacaine 1%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ HSP-KC Ketoprofen 10% / cyclobenzaprine 2%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ HSP-IBU Ibuprofen 20%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ HSP-KET Ketoprofen 10%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
☐ HSP-DIO Diclofenac 10%	QTY: ☐ 60 ☐ 120 ☐ 180 gm
FOOT CRAMPS / GOUT (select one formula)	QUANTITY
☐ FCR-GM Guaifenesin 10% / magnesium sulfate 10% cream	QTY: ☐ 60 ☐ 120 gm
☐ FCR-MG Magnesium chloride 10% / peppermint oil 1% cream	QTY: ☐ 60 ☐ 120 gm
☐ GOU-ITC Indomethacin 2% / tetracaine 2% / colchicine 0.2% cream	QTY: ☐ 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	
☐ 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.	
☐ 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 – NAIL FUNGUS & NAIL REMOVAL

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

NAIL FUNGUS – Penetrating Nail Solution (DMSO) (select one formula)	QUANTITY
☐ NAL-TI Terbinafine 3% / itraconazole 1% nail solution	QTY: ☐ 15 ☐ 30 mL
☐ NAL-FU Fluconazole 1% / urea 20% nail solution	QTY: ☐ 15 ☐ 30 mL
☐ NAL-FI Fluconazole 2% / ibuprofen 2% nail solution (mild-moderate)	QTY: ☐ 15 ☐ 30 mL
☐ NAL-KET Ketoconazole 2% nail solution (mild-moderate)	QTY: ☐ 15 ☐ 30 mL
☐ NAL-II Itraconazole 2% / ibuprofen 2% nail solution (moderate-severe)	QTY: ☐ 15 ☐ 30 mL
☐ NAL-IUTS Itraconazole 2% / undecylenic acid 17% / tea tree oil 16.7% / salicylic acid 10% nail solution (severe)	QTY: ☐ 15 ☐ 30 mL
☐ NAL-CIFT Ciclopirox 8% / itraconazole 3% / ibuprofen 2% / fluconazole 3% / terbinafine 1% nail solution (severe)	QTY: ☐ 15 ☐ 30 mL
☐ NAL-THY Thymol 4% in alcohol	QTY: ☐ 15 ☐ 30 mL
☐ NAL-EKC Erythromycin 2% / ketoconazole 2% / ciprofloxacin 1% nail solution (mixed infection)	QTY: ☐ 15 ☐ 30 mL
NAIL REMOVAL / NAIL PSORIASIS (select one formula)	QUANTITY
☐ NAL-UREA40 Urea 40% / lactic acid 10% / salicylic acid 3% cream (nail softening / chemical avulsion)	QTY: ☐ 30 ☐ 60 gm
☐ NAL-CLOB8 Clobetasol 8% nail gel	QTY: ☐ 30 ☐ 60 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 to the affected nail(s) and surrounding skin twice daily; file the nail weekly.
☐ Apply to the nail under occlusion nightly for _____ weeks.
☐ Other _____
X _____ Prescriber's Signature
_____ Date

4 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

Pharmacy Name

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Pharmacy Fax Number

NEW PRESCRIPTION ORDER FORM – CORNS, CALLUSES, DRY & SWEATY FEET (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

CORNS & CALLUSES (select one formula)	QUANTITY
☐ CRN-SPT Salicylic acid 10% / podophyllin 10% / trichloroacetic acid 10% solution (provider-applied, in office)	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
☐ CRN-SM Salicylic acid 20% / menthol 0.1% cream	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
☐ CRN-SUA Salicylic acid 5% / urea 20% / ammonium lactate 12% cream	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
ROUGH / DRY FEET (select one formula)	QUANTITY
☐ DRY-U40 Urea 40% / lactic acid 10% / salicylic acid 3% cream	QTY: ☐ 60 ☐ 120 ☐ 240 gm
☐ DRY-U20 Urea 20% gel	QTY: ☐ 60 ☐ 120 ☐ 240 gm
☐ DRY-U8 Urea 8% cream	QTY: ☐ 60 ☐ 120 ☐ 240 gm
☐ DRY-HU Sodium hyaluronate 0.5% / urea 10% gel	QTY: ☐ 60 ☐ 120 ☐ 240 gm
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 to the affected area(s) once or twice daily.	
☐ Apply a thin layer to the feet at bedtime; wash off in the morning.	
☐ Provider applies in office.	
☐ Other _____	
X _____	
Prescriber's Signature	Date

4 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

Pharmacy Name

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Pharmacy Fax Number

NEW PRESCRIPTION ORDER FORM – CORNS, CALLUSES, DRY & SWEATY FEET (2 OF 2)

1 Patient Information

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

2 Prescriber Information

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

3 Medication Selection

SWEATY FEET (HYPERHIDROSIS) (select one formula)	QUANTITY
☐ SWT-G05 Glycopyrrolate 0.5% solution (roll-on)	QTY: ☐ 30 ☐ 60 gm/mL
☐ SWT-G1C Glycopyrrolate 1% cream	QTY: ☐ 30 ☐ 60 gm/mL
☐ SWT-G1L Glycopyrrolate 1% lotion	QTY: ☐ 30 ☐ 60 gm/mL
☐ SWT-G2 Glycopyrrolate 2% wipes / solution	QTY: ☐ 30 ☐ 60 gm/mL
CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ gm/mL
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 to the affected area(s) once or twice daily.	
☐ Apply a thin layer to the feet at bedtime; wash off in the morning.	
☐ Provider applies in office.	
☐ 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 – DIABETIC TOES, CIRCULATION & RAYNAUD'S

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

CIRCULATION / RAYNAUD'S – Cream or Gel (select one formula)	QUANTITY
☐ CIR-N4 Nifedipine 4% cream	QTY: ☐ 60 ☐ 120 gm
☐ CIR-N16 Nifedipine 16% cream	QTY: ☐ 60 ☐ 120 gm
☐ CIR-P5 Pentoxifylline 5% cream	QTY: ☐ 60 ☐ 120 gm
☐ CIR-P5N2 Pentoxifylline 5% / nifedipine 2% cream	QTY: ☐ 60 ☐ 120 gm
☐ CIR-P3N3 Pentoxifylline 3% / nifedipine 3% cream	QTY: ☐ 60 ☐ 120 gm
☐ CIR-NTG Nitroglycerin 0.2% cream (digital ulcers / Raynaud's)	QTY: ☐ 60 ☐ 120 gm
☐ CIR-KGCN Ketoprofen 10% / gabapentin 6% / clonidine 0.2% / nifedipine 2% cream (painful ischemic toes)	QTY: ☐ 60 ☐ 120 gm
☐ CIR-NPK Nifedipine 10% / pentoxifylline 5% / ketoprofen 10% / gabapentin 6% / lidocaine 3% / prilocaine 3% cream	QTY: ☐ 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

☐ Apply 1mL to the affected toes/fingers 3–4 times daily.
☐ Apply a thin layer to the affected area twice daily and before cold exposure.
☐ Other _____
X _____
Prescriber's Signature _____ Date _____

4 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

Pharmacy Name

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Pharmacy Fax Number