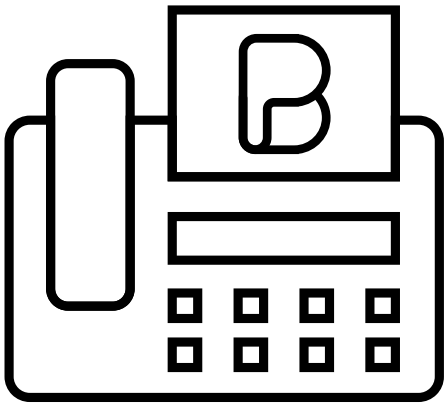
Bayview Pharmacy

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

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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 – ORAL MEDICINE (MUCOSITIS, ULCERS, THRUSH) (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

MUCOSITIS – Medicated Mouthwashes (240 mL unless stated) (select one)	QUANTITY
☐ MUC-MAGIC Magic mouthwash - diphenhydramine / antacid / lidocaine 2% (1:1:1)	QTY: ☐ 240 ☐ 480 mL
☐ MUC-MARY Mary's mouthwash - diphenhydramine / hydrocortisone / nystatin / tetracycline	QTY: ☐ 240 ☐ 480 mL
☐ MUC-DUKE Duke's mouthwash - diphenhydramine / nystatin / hydrocortisone	QTY: ☐ 240 ☐ 480 mL
☐ MUC-DUKED Duke's mouthwash with dexamethasone 2.25 mg / tetracycline 0.5 g	QTY: ☐ 240 ☐ 480 mL
☐ MUC-MILE Mile's solution - viscous lidocaine / diphenhydramine / hydrocortisone / tetracycline / nystatin	QTY: ☐ 240 ☐ 480 mL
☐ MUC-DEX Dexamethasone 0.5 mg / 5 mL oral rinse (swish and spit)	QTY: ☐ 240 ☐ 480 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

- ☐ Swish 5–10 mL for 1–2 minutes and spit, every 6 hours as needed.
- ☐ Swish, hold and swallow 15 mL every 4–6 hours as needed.
- ☐ Dissolve 1 troche in the mouth 4–5 times daily for 14 days.
- ☐ 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 – ORAL MEDICINE (MUCOSITIS, ULCERS, THRUSH) (2 OF 2) (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

APHTHOUS ULCERS, LICHEN PLANUS & BURNING MOUTH (select one formula)	QUANTITY
☐ ULC-ALD Acyclovir 5% / lidocaine 1% / deoxy-D-glucose 2% oral rinse	QTY: ☐ 60 ☐ 120 ☐ 30 mL/count
☐ ULC-TNDH Tetracycline 125 mg / nystatin 60,000 u / diphenhydramine 12.5 mg / hydrocortisone 2.3 mg troche	QTY: ☐ 60 ☐ 120 ☐ 30 mL/count
☐ LCP-TC Tretinoin 0.1% / clobetasol 0.05% oral rinse (lichen planus)	QTY: ☐ 60 ☐ 120 ☐ 30 mL/count
☐ LCP-CLOB Clobetasol 0.025% oral rinse	QTY: ☐ 60 ☐ 120 ☐ 30 mL/count
☐ LCP-PASTE Clobetasol 0.05% dental paste	QTY: ☐ 60 ☐ 120 ☐ 30 mL/count
☐ BMS-AGL Amitriptyline 2% / gabapentin 6% / lidocaine 0.5% oral rinse (burning mouth)	QTY: ☐ 60 ☐ 120 ☐ 30 mL/count
☐ BMS-DOX Doxepin 0.5% mouthwash	QTY: ☐ 60 ☐ 120 ☐ 30 mL/count
☐ BMS-SAL Salicylic acid 0.3% mouthwash	QTY: ☐ 60 ☐ 120 ☐ 30 mL/count

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

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

- ☐ Swish 5–10 mL for 1–2 minutes and spit, every 6 hours as needed.
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Pharmacy Fax Number

NEW PRESCRIPTION ORDER FORM – ORAL MEDICINE (MUCOSITIS, ULCERS, THRUSH) (2 OF 2) (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 THRUSH & BIOFILM (select one formula)	QUANTITY
☐ THR-AMBR Amphotericin B 50 mg/mL oral rinse	QTY: ☐ 60 ☐ 120 ☐ 30 mL/count
☐ THR-AMBT Amphotericin B 100 mg troche	QTY: ☐ 60 ☐ 120 ☐ 30 mL/count
☐ THR-CLO Clotrimazole 10 mg troche	QTY: ☐ 60 ☐ 120 ☐ 30 mL/count
☐ THR-NYS Nystatin 100,000 u/mL oral suspension	QTY: ☐ 60 ☐ 120 ☐ 30 mL/count
☐ BIO-AZI Azithromycin 1% biofilm oral rinse	QTY: ☐ 60 ☐ 120 ☐ 30 mL/count
☐ BIO-MET Metronidazole 1% biofilm oral rinse	QTY: ☐ 60 ☐ 120 ☐ 30 mL/count

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

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

- ☐ Swish 5–10 mL for 1–2 minutes and spit, every 6 hours as needed.
- ☐ Swish, hold and swallow 15 mL every 4–6 hours as needed.
- ☐ Dissolve 1 troche in the mouth 4–5 times daily for 14 days.
- ☐ Other _____

X _____ _____

Prescriber's Signature Date

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_____ _____

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