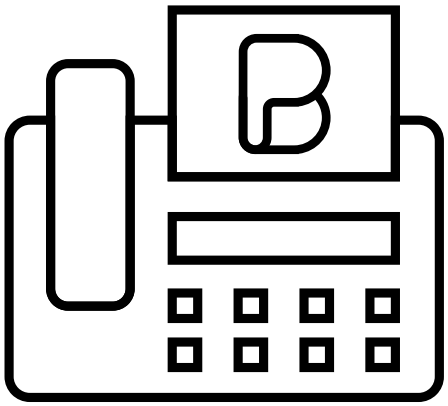
Bayview Pharmacy

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
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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 – DICLOFENAC – TOPICAL GEL

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

TOPICAL / TRANSDERMAL GEL OR CREAM – Single Agent (select one formula) — **QUANTITY**

☐ DIC-G13	Diclofenac sodium 1.3% topical gel	**QTY:** ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-G4	Diclofenac sodium 4% topical or transdermal gel or cream	**QTY:** ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-G5	Diclofenac sodium 5% topical gel	**QTY:** ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-G6	Diclofenac sodium 6% transdermal gel	**QTY:** ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-G75	Diclofenac sodium 7.5% transdermal gel	**QTY:** ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-G8	Diclofenac sodium 8% topical gel	**QTY:** ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-G10	Diclofenac sodium 10% topical or transdermal gel	**QTY:** ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-G15	Diclofenac sodium 15% topical gel	**QTY:** ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-G20	Diclofenac sodium 20% topical or transdermal gel	**QTY:** ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-GC	Diclofenac sodium _____% topical gel or cream (custom strength)	**QTY:** ☐ 30 ☐ 60 ☐ 120 gm/mL

Diclofenac sodium 1% gel (OTC), 1.5% and 2% topical solution, the 1.3% patch and oral tablets are FDA-approved. Compounded strengths above 2% and all combination preparations are not FDA-approved and are prescribed off-label. Apply to clean, intact skin only; NSAID cardiovascular and gastrointestinal warnings apply, and absorption rises with concentration, treated area, occlusion and heat.

CUSTOM – (other formula or strength – call pharmacy to confirm) — **QUANTITY**

☐ _____ **QTY:** _____ gm/mL

CONTAINER (select one – jar supplied if left blank)

☐ Jar ☐ Tube ☐ 0.5 mL metered pump ☐ 1 mL metered pump

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 joint or muscle _____ times daily and rub in; wash hands after use.

☐ Apply 1–2 mL (1–2 pumps) to the affected area _____ times daily as needed; 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-RICR-40-15-1 section 1.3A10

NEW PRESCRIPTION ORDER FORM – DICLOFENAC – COMBINATIONS

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

COMBINATION TOPICAL GEL OR CREAM (select one formula)	QUANTITY
☐ DIC-DGL Diclofenac 5% / gabapentin 10% / lidocaine 7%	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-ADG Amitriptyline 2% / diclofenac 5% / gabapentin 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-CDLM Cyclobenzaprine 2% / diclofenac 3% / lidocaine 2% / magnesium chloride 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-DGL65 Diclofenac 5% / gabapentin 6% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-DAGL Diclofenac 10% / amitriptyline 2% / gabapentin 5% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-CDL Cyclobenzaprine 2% / diclofenac 10% / lidocaine 10%	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-DL10 Diclofenac 10% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-DL5 Diclofenac 5% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-DDM Diclofenac 10% / dimethyl sulfoxide (DMSO) topical gel	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-DDMM Diclofenac 5% / DMSO 30% / menthol 4% topical gel	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-DBD Diclofenac 3% / baclofen 2% / DMSO 10% topical gel	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-VD Verapamil 10% / diclofenac 5% topical gel	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL

Combination topical preparations are compounded, are not FDA-approved and are studied less than single-ingredient topical NSAIDs. Each active carries its own cautions and interactions. Ketoprofen, ibuprofen and other combinations not listed: use the CUSTOM line below.

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

CONTAINER (select one – jar supplied if left blank)

☐ Jar ☐ Tube ☐ 0.5 mL metered pump ☐ 1 mL metered pump

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 joint or muscle _____ times daily and rub in; wash hands after use.

☐ Apply 1–2 mL (1–2 pumps) to the affected area _____ times daily as needed; 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-RICR-40-15-1 section 1.3A10

Pharmacy Fax Number

NEW PRESCRIPTION ORDER FORM – DICLOFENAC – ORAL & RECTAL

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 – Liquid, Suspension or Acid-Resistant Capsule (select one formula)	QUANTITY
☐ DIC-OL5 Diclofenac sodium 5 mg/mL oral liquid or suspension	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ DIC-OL10 Diclofenac sodium 10 mg/mL oral liquid or suspension	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ DIC-OL15 Diclofenac sodium 15 mg/mL oral liquid or suspension	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ DIC-C50 Diclofenac sodium 50 mg acid-resistant capsule - circle: immediate / slow release	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ DIC-C75 Diclofenac sodium 75 mg acid-resistant capsule - circle: immediate / slow release	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ DIC-OC Diclofenac sodium _____ mg capsule or _____ mg/mL oral liquid (custom)	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps

Oral liquids can be flavored - write the flavor on the CUSTOM line. Oral diclofenac carries the full systemic NSAID cardiovascular and gastrointestinal risk profile; screen for renal and hepatic impairment, ulcer history and concurrent NSAID or anticoagulant therapy.

RECTAL – Suppository (select one)	QUANTITY
☐ DIC-S50 Diclofenac sodium 50 mg suppository	QTY: ☐ 10 ☐ 30 count
☐ DIC-SC Diclofenac sodium _____ mg suppository (custom strength)	QTY: ☐ 10 ☐ 30 count

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

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Take _____ mL by mouth _____ times daily with food.

☐ Take 1 capsule by mouth _____ times daily with food.

☐ Insert 1 suppository rectally _____ times daily 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