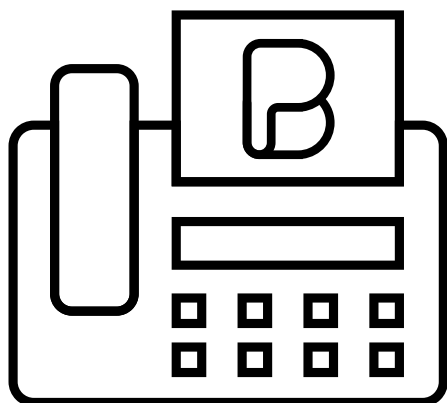




Your modern compounding pharmacy.™

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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Your modern compounding pharmacy. TM

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 – SCOPOLAMINE – TRANSDERMAL GEL & CREAM

1 Patient Information

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

2 Prescriber Information

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

3 Medication Selection

TRANSDERMAL GEL (measured applicator)	QUANTITY
☐ SCO-G025 Scopolamine HBr 0.25 mg/0.1 mL transdermal gel	QTY: ☐ 10 ☐ 30 mL
☐ SCO-G04 Scopolamine HBr 0.4 mg/0.1 mL transdermal gel	QTY: ☐ 10 ☐ 30 mL
TOPICAL CREAM	QUANTITY
☐ SCO-C025 Scopolamine HBr 0.25 mg/mL topical cream	QTY: ☐ 30 g
☐ SCO-C25 Scopolamine HBr 2.5 mg/mL topical cream	QTY: ☐ 30 g

Off-label; the FDA-approved scopolamine products are the transdermal patch (about 1 mg over 3 days) and the injection, and oral scopolamine is not marketed in the US. Contraindicated in angle-closure glaucoma. Write an explicit maximum number of doses in 24 hours. Combination capsules and methscopolamine preparations are ordered on their own forms.

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

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Apply 0.1 mL to the inner wrist or behind the ear every 8 hours as needed for nausea or motion sickness. No more than 3 doses in 24 hours. Wash hands after applying. Do not use with a scopolamine patch.

☐ Apply 0.1 mL to _____ hours before travel; may repeat every _____ hours as needed. No more than _____ doses in 24 hours. Wash hands after applying.

☐ Apply _____ to _____ times daily as directed. No more than _____ doses in 24 hours.

☐ 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 – SCOPOLAMINE – CAPSULES, TROCHE, SUSPENSION & NASAL SPRAY

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 CAPSULES	QUANTITY
☐ SCO-K02 Scopolamine HBr 0.2 mg oral capsule	QTY: ☐ 30 ☐ 50 capsules
☐ SCO-K04 Scopolamine HBr 0.4 mg oral capsule	QTY: ☐ 30 ☐ 50 capsules
☐ SCO-K12 Scopolamine HBr 1.2 mg oral capsule	QTY: ☐ 30 ☐ 50 capsules
☐ SCO-K05S Scopolamine HBr 0.5 mg slow-release oral capsule	QTY: ☐ 30 ☐ 50 capsules
☐ SCO-K1S Scopolamine HBr 1 mg slow-release oral capsule	QTY: ☐ 30 ☐ 50 capsules
ORAL TROCHE	QUANTITY
☐ SCO-T04 Scopolamine HBr 0.4 mg oral troche	QTY: ☐ 30 troches
ORAL SUSPENSION (oral syringe)	QUANTITY
☐ SCO-S01 Scopolamine HBr 0.1 mg/mL oral suspension	QTY: ☐ 30 ☐ 60 mL
NASAL SPRAY (metered pump)	QUANTITY
☐ SCO-N02 Scopolamine HBr 0.2% nasal spray	QTY: ☐ 5 ☐ 24 mL
Off-label; the FDA-approved scopolamine products are the transdermal patch (about 1 mg over 3 days) and the injection, and oral scopolamine is not marketed in the US. Contraindicated in angle-closure glaucoma. Write an explicit maximum number of doses in 24 hours. Combination capsules and methscopolamine preparations are ordered on their own forms.	
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

☐ Take 1 capsule by mouth 1 hour before travel; may repeat once in 8 hours if needed. No more than 2 doses in 24 hours.
☐ Take _____ by mouth every _____ hours as needed for nausea. No more than _____ doses in 24 hours.
☐ Nasal spray: 1 spray in one nostril every _____ hours as needed. No more than _____ sprays in 24 hours.
☐ 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