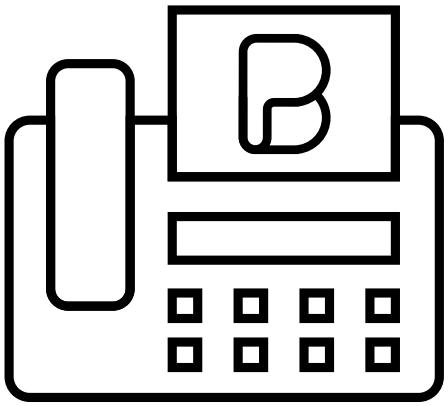
Bayview Pharmacy

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
www.bayviewrx.com

# Bayview Pharmacy

**Your modern compounding pharmacy. ™**

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 – CYCLOBENZAPRINE – TOPICAL GEL & CREAM

## 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 GEL (anhydrous base, metered pump) | QUANTITY |
|---|---|
| ☐ CYC-G05 Cyclobenzaprine HCl 0.5% topical gel | QTY: ☐ 30 ☐ 60 ☐ 100 g |
| ☐ CYC-G1 Cyclobenzaprine HCl 1% topical gel | QTY: ☐ 30 ☐ 60 ☐ 100 g |
| ☐ CYC-G2 Cyclobenzaprine HCl 2% (20 mg/g) topical gel | QTY: ☐ 30 ☐ 60 ☐ 100 g |
| ☐ CYC-G5 Cyclobenzaprine HCl 5% topical gel | QTY: ☐ 30 ☐ 60 ☐ 100 g |

| TOPICAL CREAM (on request) | QUANTITY |
|---|---|
| ☐ CYC-C Cyclobenzaprine HCl ____% topical cream | QTY: ☐ 30 ☐ 60 g |

Off-label; the FDA-approved cyclobenzaprine products are the 5, 7.5, and 10 mg tablets and the 15 and 30 mg extended-release capsules, indicated for up to 2 to 3 weeks. Contraindicated with an MAOI within 14 days, in the acute recovery phase of MI, arrhythmias, heart block, heart failure, and hyperthyroidism; serotonin syndrome with serotonergic drugs; avoid in patients 65 and older. Specify a duration. Combination gels are ordered on the topical pain cream form.

| 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 1 to 2 pumps to the affected muscle and rub in two to three times daily for up to 14 days. Do not apply to broken skin. Wash hands after applying.

☐ Apply _____ pump(s) to _____ _____ times daily for _____ days. Do not apply to broken skin. Wash hands after applying.

☐ 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 – CYCLOBENZAPRINE – ORAL LIQUID, TROCHE & CAPSULES

## 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 (oral syringe) | QUANTITY |
|---|---|
| ☐ CYC-L1 Cyclobenzaprine HCl 1 mg/mL oral liquid | QTY: ☐ 60 ☐ 120 mL |
| ☐ CYC-L2 Cyclobenzaprine HCl 2 mg/mL oral liquid | QTY: ☐ 60 ☐ 120 mL |
| **ORAL TROCHE** | **QUANTITY** |
| ☐ CYC-T10 Cyclobenzaprine HCl 10 mg oral troche | QTY: ☐ 30 troches |
| **ORAL CAPSULES (custom strength)** | **QUANTITY** |
| ☐ CYC-K Cyclobenzaprine HCl ____ mg oral capsule | QTY: ☐ 30 ☐ 60 capsules |

Off-label; the FDA-approved cyclobenzaprine products are the 5, 7.5, and 10 mg tablets and the 15 and 30 mg extended-release capsules, indicated for up to 2 to 3 weeks. Contraindicated with an MAOI within 14 days, in the acute recovery phase of MI, arrhythmias, heart block, heart failure, and hyperthyroidism; serotonin syndrome with serotonergic drugs; avoid in patients 65 and older. Specify a duration. Combination gels are ordered on the topical pain cream form. Manufactured tablets are available in 5, 7.5, and 10 mg; order a compounded capsule only when a strength, excipient-free formulation, or dosage form the tablets do not offer is needed.

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

**REFILLS (circle one)**

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

**DIRECTIONS/SIG + SIGNATURE**

☐ Take _____ mL ( _____ mg) by mouth three times daily for up to 14 days.

☐ Dissolve 1 troche in the mouth _____ times daily for up to 14 days. Do not chew or swallow whole.

☐ Take 1 capsule by mouth _____ times daily for _____ 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