



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 – CICLOPIROX – SKIN & SCALP

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

CREAM & GEL QUANTITY

☐ CIC-C6 Ciclopirox olamine 6% topical cream	QTY: ☐ 30 ☐ 60 g
☐ CIC-G6 Ciclopirox olamine 6% topical gel	QTY: ☐ 30 ☐ 60 g

Manufactured ciclopirox 0.77% cream, gel, and suspension, the 1% shampoo, and the 8% nail lacquer are FDA-approved products; if one of those fits, order it as such and we will dispense the manufactured product. Compounding is for a higher strength, a different vehicle, or a container size the manufactured line does not offer. Compounded preparations are not FDA-approved.

TOPICAL SOLUTION QUANTITY

☐ CIC-S15 Ciclopirox olamine 1.5% topical solution	QTY: ☐ 30 ☐ 60 mL
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MEDICATED SHAMPOO QUANTITY

☐ CIC-SH15 Ciclopirox olamine 1.5% shampoo	QTY: ☐ 120 ☐ 240 mL
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Not for ophthalmic, oral, or intravaginal use. Avoid occlusion. Discontinue on sensitivity or irritation; re-evaluate the diagnosis if no improvement after 4 weeks. Pediatric: cream not established under 10, shampoo under 16.

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

☐ _____	QTY: _____ mL
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REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Massage into the affected and surrounding skin twice daily, morning and evening, for 4 weeks. Do not occlude.
☐ Apply to _____ times daily for _____ weeks.
☐ Shampoo: apply 5 to 10 mL to wet scalp, lather, leave 3 minutes, rinse; twice weekly for 4 weeks, at least 3 days apart.
☐ 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 – CICLOPIROX – NAIL LACQUER

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 LACQUER (brush-on) QUANTITY

☐ CIC-L777 Ciclopirox olamine 7.77% nail lacquer	QTY: ☐ 6.6 ☐ 15 mL
☐ CIC-L8 Ciclopirox olamine 8% nail lacquer, vehicle: _____	QTY: ☐ 6.6 ☐ 15 mL

Onychomycosis: confirm mycology (KOH, culture, or PAS) before a 48-week course. Manufactured 8% lacquer label: complete cure 5.5 to 8.5% at 48 weeks with monthly debridement; not studied in diabetic or immunosuppressed patients; weigh the risk of nail removal in diabetes; pediatric under 12 not established. The 8% is compounded only when a vehicle the manufactured lacquer does not offer is needed. Flammable; no nail polish over it; remove with alcohol every 7 days.

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

☐ _____	QTY: _____ mL
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REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Apply to affected nails and adjacent skin once daily at bedtime over the previous coat for up to 48 weeks. Remove with alcohol every 7 days. Trim unattached nail monthly (professional debridement).
☐ Apply to _____ nail(s) once daily for _____ weeks. Remove with alcohol every 7 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-RI-CR-40-15-1 section 1.3A10

Pharmacy Fax Number