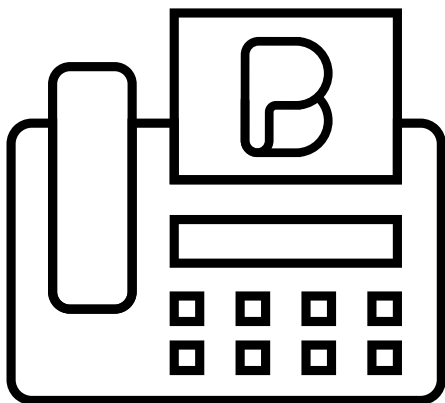




Your modern compounding pharmacy.™

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
www.bayviewrx.com



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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.

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 – CLOBETASOL – OINTMENT, FOAM, GEL & 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

OINTMENT	QUANTITY
☐ CLB-O10 Clobetasol propionate 0.1% topical ointment	QTY: ☐ 15 ☐ 30 ☐ 120 g
☐ CLB-O20 Clobetasol propionate 0.2% topical ointment	QTY: ☐ 15 ☐ 30 ☐ 120 g
Manufactured clobetasol propionate 0.05% products are FDA-approved; order those as such unless a compounded strength, base, or combination is required.	
FOAM	QUANTITY
☐ CLB-F05 Clobetasol propionate 0.05% topical foam	QTY: ☐ 50 ☐ 100 g
GEL	QUANTITY
☐ CLB-G05 Clobetasol propionate 0.05% topical / vaginal gel (skin or vulvar)	QTY: ☐ 15 ☐ 30 g
SCALP	QUANTITY
☐ CLB-SK Clobetasol propionate 0.05% / ketoconazole 2% topical liquid	QTY: ☐ 60 ☐ 120 mL
☐ CLB-SZS Clobetasol propionate 0.05% / zinc pyrithione 1% shampoo	QTY: ☐ 60 ☐ 120 mL
☐ CLB-SZP Clobetasol propionate 0.05% / zinc pyrithione 0.25% topical spray	QTY: ☐ 60 ☐ 120 mL
CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ mL

CONTAINER (ointment / gel)

☐ Jar ☐ Tube ☐ Jar supplied if left blank

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 area(s) twice daily for up to 2 weeks, then reassess. No more than 50 g per week. Do not occlude.

☐ Apply a thin layer to the affected area(s) _____ times daily for _____ days. Maximum _____ g per week.

☐ Apply to the affected area(s) of the scalp as directed, then rinse.

☐ 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 – CLOBETASOL – ORAL & VAGINAL

1 Patient Information

Last Name	First Name	MI
Address		Apt. #
City	State	ZIP
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 GEL / PASTE QUANTITY

☐ CLB-D05 Clobetasol propionate 0.05% dental gel / paste	QTY: ☐ 15 ☐ 30 ☐ 60 g
☐ CLB-DL Lidocaine 1% / clobetasol propionate 0.05% oral gel	QTY: ☐ 15 ☐ 30 ☐ 60 g

ORAL RINSE QUANTITY

☐ CLB-R05 Clobetasol propionate 0.05% oral rinse (swish and spit)	QTY: ☐ 60 ☐ 120 ☐ 240 mL
☐ CLB-R025 Clobetasol propionate 0.025% oral rinse (swish and spit)	QTY: ☐ 60 ☐ 120 ☐ 240 mL

Oral preparations are for the inside of the mouth and are not swallowed. Oral use is off-label. Counsel on oral candidiasis with extended courses.

VAGINAL SUPPOSITORY QUANTITY

☐ CLB-V05 Clobetasol propionate 0.5 mg vaginal suppository	QTY: ☐ 14 ☐ 28 supp
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Vaginal use is off-label.

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

☐ _____	QTY: _____ supp
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REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Oral gel: dry the area and apply a thin layer to the lesion(s) _____ times daily. Nothing by mouth for 30 minutes after.
☐ Oral rinse: swish _____ mL for 2 to 3 minutes and spit _____ times daily. Do not swallow. Nothing by mouth for 30 minutes after.
☐ Insert 1 suppository vaginally _____ as directed.
☐ 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