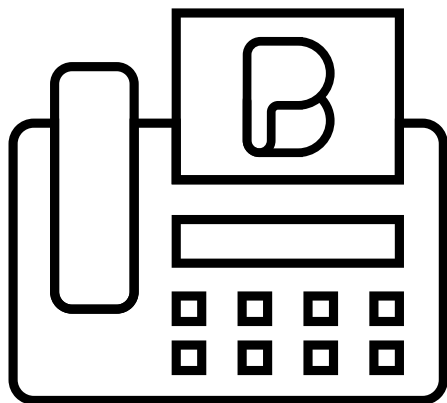




Your modern compounding pharmacy.™

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 – TRIAMCINOLONE – TOPICAL

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 OR OINTMENT (circle base; preservative-free or simplified base on request) QUANTITY

☐ TRI-025 Triamcinolone acetonide 0.025% cream / ointment	QTY: ☐ 30 ☐ 60 ☐ 120 g
☐ TRI-1 Triamcinolone acetonide 0.1% cream / ointment	QTY: ☐ 30 ☐ 60 ☐ 120 g
☐ TRI-5 Triamcinolone acetonide 0.5% cream / ointment	QTY: ☐ 30 ☐ 60 ☐ 120 g

Manufactured triamcinolone acetonide 0.025%, 0.1%, and 0.5% cream and ointment, the lotion, the topical spray, and the 0.1% dental paste are FDA-approved products; if one of those fits, order it as such and we will dispense the manufactured product. Compounding is for another strength, a preservative-free or simplified base, a gel, solution, or shampoo, a different container size, or the oral rinse. Compounded preparations are not FDA-approved.

GEL, LOTION, SOLUTION & SPRAY QUANTITY

☐ TRI-G5 Triamcinolone acetonide 0.5% topical gel	QTY: ☐ 30 ☐ 60 ☐ 120 g/mL
☐ TRI-L05 Triamcinolone acetonide 0.05% topical lotion	QTY: ☐ 30 ☐ 60 ☐ 120 g/mL
☐ TRI-S1 Triamcinolone acetonide 0.1% topical solution	QTY: ☐ 30 ☐ 60 ☐ 120 g/mL
☐ TRI-SP Triamcinolone acetonide 0.04% topical spray	QTY: ☐ 30 ☐ 60 ☐ 120 g/mL

MEDICATED SHAMPOO QUANTITY

☐ TRI-SH025 Triamcinolone acetonide 0.025% shampoo	QTY: ☐ 120 ☐ 240 mL
☐ TRI-SH1 Triamcinolone acetonide 0.1% shampoo	QTY: ☐ 120 ☐ 240 mL

Specify site, frequency, duration, and whether occlusion is permitted. Not for the face, groin, or intertriginous areas unless intended. Systemic absorption (HPA suppression, hyperglycemia) rises with the 0.5% strength, large areas, occlusion, prolonged courses, and in children.

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

☐ Apply a thin film to the affected area two to three times daily for 14 days. Do not occlude. Not for the face or skin folds.
☐ Apply a thin film to _____ times daily for _____ days. Occlusion: yes / no.
☐ Shampoo: apply to wet scalp, lather, leave on 5 minutes, rinse; use _____ times weekly for _____ weeks.
☐ 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 – TRIAMCINOLONE – ORAL PASTE & RINSE

1 Patient Information

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

2 Prescriber Information

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

3 Medication Selection

ORAL ADHESIVE PASTE

QUANTITY

☐ **TRI-P1** Triamcinolone acetonide 0.1% oral adhesive paste QTY: ☐ 5 ☐ 15 g

Manufactured triamcinolone acetonide 0.1% dental paste is FDA-approved; if it fits, order it as such and we will dispense the manufactured product.

ORAL RINSE (swish and spit)

QUANTITY

☐ **TRI-R1** Triamcinolone acetonide 0.1% oral rinse QTY: ☐ 240 mL

☐ **TRI-R2** Triamcinolone acetonide 0.2% oral rinse QTY: ☐ 240 mL

☐ **TRI-R4** Triamcinolone acetonide 0.4% oral rinse, preservative-free QTY: ☐ 240 mL

Oral rinse: swish and expectorate, do not swallow, nothing by mouth for 30 minutes after. Paste: press a small dab onto the lesion without rubbing. Contraindicated in fungal, viral, or bacterial infections of the mouth or throat; if no significant repair in 7 days, re-evaluate. Oral candidiasis is the common complication of intraoral steroid courses.

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

☐ Press a small dab onto the lesion at bedtime, or two to three times daily after meals, until a thin film forms; do not rub in. Use for up to 14 days.

☐ Swish 5 mL for 2 minutes and spit three times daily after meals for 14 days. Do not swallow. Nothing by mouth for 30 minutes after.

☐ Swish _____ mL for _____ minutes and spit _____ times daily for _____ days. Do not swallow.

☐ 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