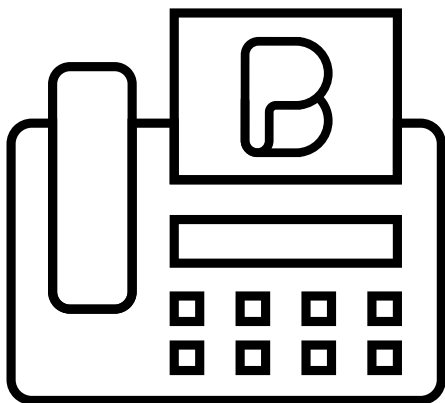




Your modern compounding pharmacy.™

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 – 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-RI-CR-40-15-1 section 1.3A10

Pharmacy Fax Number