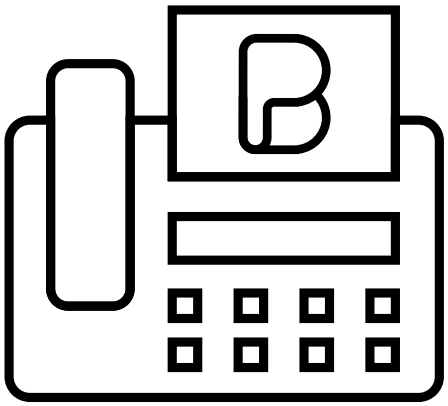
Bayview Pharmacy

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
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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 – SCOPOLAMINE – TRANSDERMAL 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

| TRANSDERMAL GEL (measured applicator) | QUANTITY |
|---|---|
| ☐ SCO-G025 Scopolamine HBr 0.25 mg/0.1 mL transdermal gel | QTY: ☐ 10 ☐ 30 mL |
| ☐ SCO-G04 Scopolamine HBr 0.4 mg/0.1 mL transdermal gel | QTY: ☐ 10 ☐ 30 mL |

| TOPICAL CREAM | QUANTITY |
|---|---|
| ☐ SCO-C025 Scopolamine HBr 0.25 mg/mL topical cream | QTY: ☐ 30 g |
| ☐ SCO-C25 Scopolamine HBr 2.5 mg/mL topical cream | QTY: ☐ 30 g |

Off-label; the FDA-approved scopolamine products are the transdermal patch (about 1 mg over 3 days) and the injection, and oral scopolamine is not marketed in the US. Contraindicated in angle-closure glaucoma. Write an explicit maximum number of doses in 24 hours. Combination capsules and methscopolamine preparations are ordered on their own forms.

| 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 0.1 mL to the inner wrist or behind the ear every 8 hours as needed for nausea or motion sickness. No more than 3 doses in 24 hours. Wash hands after applying. Do not use with a scopolamine patch.

☐ Apply 0.1 mL to _____ _____ hours before travel; may repeat every _____ hours as needed. No more than _____ doses in 24 hours. Wash hands after applying.

☐ Apply _____ to _____ _____ times daily as directed. No more than _____ doses in 24 hours.

☐ 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 – SCOPOLAMINE – CAPSULES, TROCHE, SUSPENSION & NASAL SPRAY

## 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 CAPSULES | QUANTITY |
|---|---|
| ☐ SCO-K02 Scopolamine HBr 0.2 mg oral capsule | QTY: ☐ 30 ☐ 50 capsules |
| ☐ SCO-K04 Scopolamine HBr 0.4 mg oral capsule | QTY: ☐ 30 ☐ 50 capsules |
| ☐ SCO-K12 Scopolamine HBr 1.2 mg oral capsule | QTY: ☐ 30 ☐ 50 capsules |
| ☐ SCO-K05S Scopolamine HBr 0.5 mg slow-release oral capsule | QTY: ☐ 30 ☐ 50 capsules |
| ☐ SCO-K1S Scopolamine HBr 1 mg slow-release oral capsule | QTY: ☐ 30 ☐ 50 capsules |
| **ORAL TROCHE** | **QUANTITY** |
| ☐ SCO-T04 Scopolamine HBr 0.4 mg oral troche | QTY: ☐ 30 troches |
| **ORAL SUSPENSION (oral syringe)** | **QUANTITY** |
| ☐ SCO-S01 Scopolamine HBr 0.1 mg/mL oral suspension | QTY: ☐ 30 ☐ 60 mL |
| **NASAL SPRAY (metered pump)** | **QUANTITY** |
| ☐ SCO-N02 Scopolamine HBr 0.2% nasal spray | QTY: ☐ 5 ☐ 24 mL |

Off-label; the FDA-approved scopolamine products are the transdermal patch (about 1 mg over 3 days) and the injection, and oral scopolamine is not marketed in the US. Contraindicated in angle-closure glaucoma. Write an explicit maximum number of doses in 24 hours. Combination capsules and methscopolamine preparations are ordered on their own forms.

| 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**

☐ Take 1 capsule by mouth 1 hour before travel; may repeat once in 8 hours if needed. No more than 2 doses in 24 hours.

☐ Take _____ by mouth every _____ hours as needed for nausea. No more than _____ doses in 24 hours.

☐ Nasal spray: 1 spray in one nostril every _____ hours as needed. No more than _____ sprays in 24 hours.

☐ Other _____

X _____ _____

Prescriber's Signature Date

## 4 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

_____ _____

Pharmacy Name Pharmacy Fax Number

The pharmacy name & fax # cannot be pre-printed in order to comply with RI Law 216-RICR-40-15-1 section 1.3A10