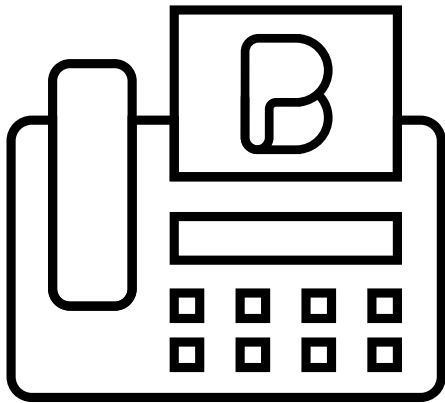




Your modern compounding pharmacy.™

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



Your modern compounding pharmacy.™

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 – DICLOFENAC – TOPICAL GEL

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 / TRANSDERMAL GEL OR CREAM – Single Agent (select one formula)	QUANTITY
☐ DIC-G13 Diclofenac sodium 1.3% topical gel	QTY: ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-G4 Diclofenac sodium 4% topical or transdermal gel or cream	QTY: ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-G5 Diclofenac sodium 5% topical gel	QTY: ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-G6 Diclofenac sodium 6% transdermal gel	QTY: ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-G75 Diclofenac sodium 7.5% transdermal gel	QTY: ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-G8 Diclofenac sodium 8% topical gel	QTY: ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-G10 Diclofenac sodium 10% topical or transdermal gel	QTY: ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-G15 Diclofenac sodium 15% topical gel	QTY: ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-G20 Diclofenac sodium 20% topical or transdermal gel	QTY: ☐ 30 ☐ 60 ☐ 120 gm/mL
☐ DIC-GC Diclofenac sodium _____% topical gel or cream (custom strength)	QTY: ☐ 30 ☐ 60 ☐ 120 gm/mL

Diclofenac sodium 1% gel (OTC), 1.5% and 2% topical solution, the 1.3% patch and oral tablets are FDA-approved. Compounded strengths above 2% and all combination preparations are not FDA-approved and are prescribed off-label. Apply to clean, intact skin only; NSAID cardiovascular and gastrointestinal warnings apply, and absorption rises with concentration, treated area, occlusion and heat.

CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ gm/mL

CONTAINER (select one – jar supplied if left blank)

☐ Jar ☐ Tube ☐ 0.5 mL metered pump ☐ 1 mL metered pump

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 joint or muscle _____ times daily and rub in; wash hands after use.
☐ Apply 1–2 mL (1–2 pumps) to the affected area _____ times daily as needed; do not apply to broken skin.
☐ 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 – DICLOFENAC – COMBINATIONS

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

COMBINATION TOPICAL GEL OR CREAM (select one formula)	QUANTITY
☐ DIC-DGL Diclofenac 5% / gabapentin 10% / lidocaine 7%	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-ADG Amitriptyline 2% / diclofenac 5% / gabapentin 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-CDLM Cyclobenzaprine 2% / diclofenac 3% / lidocaine 2% / magnesium chloride 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-DGL65 Diclofenac 5% / gabapentin 6% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-DAGL Diclofenac 10% / amitriptyline 2% / gabapentin 5% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-CDL Cyclobenzaprine 2% / diclofenac 10% / lidocaine 10%	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-DL10 Diclofenac 10% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-DL5 Diclofenac 5% / lidocaine 5%	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-DDM Diclofenac 10% / dimethyl sulfoxide (DMSO) topical gel	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-DDMM Diclofenac 5% / DMSO 30% / menthol 4% topical gel	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-DBD Diclofenac 3% / baclofen 2% / DMSO 10% topical gel	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL
☐ DIC-VD Verapamil 10% / diclofenac 5% topical gel	QTY: ☐ 60 ☐ 120 ☐ 180 gm/mL

Combination topical preparations are compounded, are not FDA-approved and are studied less than single-ingredient topical NSAIDs. Each active carries its own cautions and interactions. Ketoprofen, ibuprofen and other combinations not listed: use the CUSTOM line below.

CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ gm/mL

CONTAINER (select one – jar supplied if left blank)
☐ Jar ☐ Tube ☐ 0.5 mL metered pump ☐ 1 mL metered pump

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 joint or muscle _____ times daily and rub in; wash hands after use.
☐ Apply 1–2 mL (1–2 pumps) to the affected area _____ times daily as needed; do not apply to broken skin.
☐ 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–R/CR–40–15–1 section 1.3A10

Pharmacy Fax Number

NEW PRESCRIPTION ORDER FORM – DICLOFENAC – ORAL & RECTAL

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, Suspension or Acid-Resistant Capsule (select one formula)	QUANTITY
☐ DIC-OL5 Diclofenac sodium 5 mg/mL oral liquid or suspension	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ DIC-OL10 Diclofenac sodium 10 mg/mL oral liquid or suspension	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ DIC-OL15 Diclofenac sodium 15 mg/mL oral liquid or suspension	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ DIC-C50 Diclofenac sodium 50 mg acid-resistant capsule - circle: immediate / slow release	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ DIC-C75 Diclofenac sodium 75 mg acid-resistant capsule - circle: immediate / slow release	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ DIC-OC Diclofenac sodium _____ mg capsule or _____ mg/mL oral liquid (custom)	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps

Oral liquids can be flavored - write the flavor on the CUSTOM line. Oral diclofenac carries the full systemic NSAID cardiovascular and gastrointestinal risk profile; screen for renal and hepatic impairment, ulcer history and concurrent NSAID or anticoagulant therapy.

RECTAL – Suppository (select one)	QUANTITY
☐ DIC-S50 Diclofenac sodium 50 mg suppository	QTY: ☐ 10 ☐ 30 count
☐ DIC-SC Diclofenac sodium _____ mg suppository (custom strength)	QTY: ☐ 10 ☐ 30 count

CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ count

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Take _____ mL by mouth _____ times daily with food.
☐ Take 1 capsule by mouth _____ times daily with food.
☐ Insert 1 suppository rectally _____ times daily as needed.
☐ 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-RCR-40-15-1 section 1.3A10

Pharmacy Fax Number