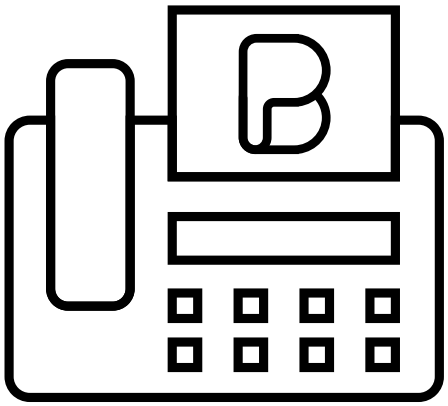
Bayview Pharmacy

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

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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 – TACROLIMUS

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

TACROLIMUS – Otic Solution	QUANTITY
☐ TAC-OT1 Tacrolimus 0.1% otic solution	QTY: ☐ 15 mL
☐ TAC-OT2 Tacrolimus 0.2% otic solution	QTY: ☐ 15 ☐ 30 mL

TACROLIMUS – Rectal Enema	QUANTITY
☐ TAC-ER Tacrolimus 4 mg / 60 mL rectal enema	QTY: _____ enemas

TACROLIMUS – Topical	QUANTITY
☐ TAC-G1 Tacrolimus 0.1% anhydrous gel (WO6)	QTY: ☐ 30 gm
☐ TAC-CK Tacrolimus 0.1% with ketotifen 0.05% cream	QTY: ☐ 60 gm

TACROLIMUS – Scalp	QUANTITY
☐ TAC-SH Tacrolimus 0.1% shampoo (VersaBase)	QTY: ☐ 60 ☐ 100 mL
☐ TAC-FM Minoxidil 5% / tacrolimus 0.3% / clobetasol 0.05% foam	QTY: ☐ 30 mL

For rectal courses or extensive application, consider whole-blood tacrolimus levels and renal function. State a course length.

CUSTOM – (other strength, base or form – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ units

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

- ☐ Instill _____ drops into the affected ear twice daily for ____ days.
- ☐ Administer one 60 mL enema per rectum at bedtime for _____ weeks.
- ☐ Apply a thin layer to the affected area(s) twice daily.
- ☐ 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