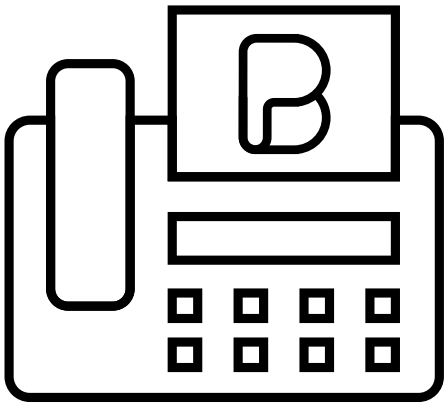
Bayview Pharmacy

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 – CUSTOM ORAL SUSPENSIONS

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

ANY MEDICATION – compounded to your order — **QUANTITY**

☐ Medication + concentration (mg/mL): _____ **QTY:** _____ mL

CONTROLLED SUBSTANCES CANNOT BE ORDERED ON THIS FORM – ketamine, methylphenidate, hydromorphone and clonazepam must be e-prescribed.

COMMONLY COMPOUNDED – write in the concentration — **QUANTITY**

☐ **GUA** Guanfacine suspension _____ mg/mL (0.25 / 0.5 / 1 / 1.5 / 2) **QTY:** _____ mL

☐ **LEU** Leucovorin suspension, anhydrous _____ mg/mL (2.5 / 5 / 10 / 15 / 20) **QTY:** _____ mL

☐ **OME** Omeprazole suspension _____ mg/mL (2 / 6 / 8 / 10) **QTY:** _____ mL

☐ **OME-C** Omeprazole 20 mg delayed-release capsules **QTY:** _____ caps

FORMULATION OPTIONS – apply to any selection above

Vehicle: ☐ Anhydrous (water-free) ☐ Aqueous ☐ Pharmacy's choice

Exclude: ☐ Dye-free ☐ Sugar-free ☐ Alcohol-free

Feeding tube: ☐ NG ☐ PEG ☐ G-tube ☐ Flush before and after

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Give _____ mL by mouth once daily.

☐ Give _____ mL by mouth 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 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