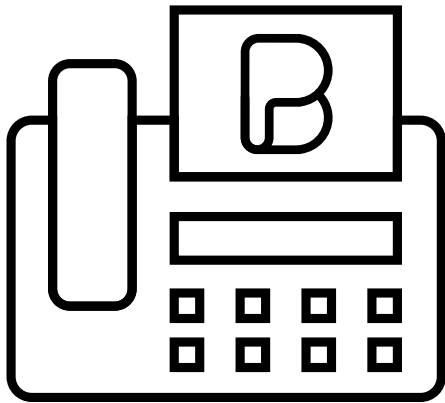




Your modern compounding pharmacy.™

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 – VAGINAL INFECTIONS

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

YEAST / CANDIDA (incl. <i>C. glabrata</i>) – Vaginal (select one formula)	QUANTITY
☐ VIN-BOR600 Boric acid 600 mg vaginal suppository	QTY: ☐ 14 ☐ 30 count/gm
☐ VIN-BOR30 Boric acid 30% vaginal gel or cream	QTY: ☐ 14 ☐ 30 count/gm
☐ VIN-BORE Boric acid 30% / edetate disodium 0.5% vaginal gel (biofilm)	QTY: ☐ 14 ☐ 30 count/gm
☐ VIN-AMB50 Amphotericin B 50 mg vaginal suppository	QTY: ☐ 14 ☐ 30 count/gm
☐ VIN-NYS Nystatin 100,000 units vaginal suppository	QTY: ☐ 14 ☐ 30 count/gm
☐ VIN-FLUC Fluconazole 150 mg / boric acid 600 mg vaginal suppository	QTY: ☐ 14 ☐ 30 count/gm
BACTERIAL VAGINOSIS / MIXED – Vaginal (select one formula)	QUANTITY
☐ VBV-MN Metronidazole 1% / nystatin 100,000 u/g vaginal cream	QTY: ☐ 30 ☐ 60 ☐ 14 gm/count
☐ VBV-CHX Chlorhexidine 0.5% / 0.625% vaginal gel (circle)	QTY: ☐ 30 ☐ 60 ☐ 14 gm/count
☐ VBV-CIP Ciprofloxacin 2% vaginal gel	QTY: ☐ 30 ☐ 60 ☐ 14 gm/count
☐ VBV-CLIN Clindamycin 2% vaginal cream	QTY: ☐ 30 ☐ 60 ☐ 14 gm/count
☐ VBV-ACE Acetic acid 0.9% / hydroxyquinoline 0.025% vaginal gel	QTY: ☐ 30 ☐ 60 ☐ 14 gm/count
☐ VBV-ASC Ascorbic acid 25% vaginal gel	QTY: ☐ 30 ☐ 60 ☐ 14 gm/count
☐ VBV-MUP Mupirocin 10 mg / 20 mg vaginal suppository (circle)	QTY: ☐ 30 ☐ 60 ☐ 14 gm/count
CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____ QTY: _____ gm/count	

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Insert 1 suppository vaginally at bedtime for 14 nights.
☐ Insert 1 applicator (2 g) vaginally at bedtime for 14 nights.
☐ Insert 1 g vaginally once daily for 14 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 _____

NEW PRESCRIPTION ORDER FORM – VAGINAL DRYNESS, ATROPHY & LIBIDO

1 Patient Information

Last Name	First Name	MI
Address		Apt. #
City	State	ZIP
Date of Birth (mm/dd/yyyy)		Phone Number
Sex	OM OF	Email

2 Prescriber Information

Prescriber's Name		
Phone Number	Fax Number	
Street Address		
City	State	ZIP
NPI	DEA	

3 Medication Selection

NON-HORMONAL MOISTURIZERS – Vaginal (for estrogen options see the Estrogen Vaginal form) (select one formula) QUANTITY

☐ VDR-HA Sodium hyaluronate 5 mg/g vaginal gel	QTY: ☐ 30 ☐ 60 ☐ 30 gm/count
☐ VDR-VITE Vitamin E 200 IU vaginal suppository or 200 u/g gel (circle)	QTY: ☐ 30 ☐ 60 ☐ 30 gm/count
☐ VDR-GLY Glycerin / caprylic-capric triglyceride vaginal suppository	QTY: ☐ 30 ☐ 60 ☐ 30 gm/count
☐ VDR-AEH Vitamin A 0.1% / vitamin E 0.1% / sodium hyaluronate 0.5% vaginal cream	QTY: ☐ 30 ☐ 60 ☐ 30 gm/count
☐ VDR-DHEA DHEA 13 mg/g vaginal gel or 6.5 mg vaginal suppository (circle)	QTY: ☐ 30 ☐ 60 ☐ 30 gm/count

LIBIDO / AROUSAL – Vaginal Cream (metered pump) (select one formula) QUANTITY

☐ LIB-AT Arginine 6% / theophylline 2.5% vaginal cream (scream cream)	QTY: ☐ 30 ☐ 60 gm
☐ LIB-ATS Arginine 6% / theophylline 2.5% / sildenafil 2% vaginal cream	QTY: ☐ 30 ☐ 60 gm
☐ LIB-SN Sildenafil 3% / nitroglycerin 0.2% vaginal cream	QTY: ☐ 30 ☐ 60 gm
☐ LIB-OXY Oxytocin 120 units/g vaginal gel	QTY: ☐ 30 ☐ 60 gm
☐ LIB-OXC Oxytocin 20 units/g cream	QTY: ☐ 30 ☐ 60 gm
☐ LIB-PA Papaverine 0.1% / arginine 6% topical cream	QTY: ☐ 30 ☐ 60 gm

CUSTOM – (other formula or strength – call pharmacy to confirm) QUANTITY

☐ _____	QTY: _____ gm
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REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Insert 1g (1 pump) vaginally at bedtime; then 2–3 times weekly.
☐ Apply 0.5 mL (1 pump) to the clitoris 15–30 minutes before intercourse.
☐ Insert 1 suppository vaginally at bedtime.
☐ 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 _____

NEW PRESCRIPTION ORDER FORM – VULVAR CONDITIONS & PROCEDURE ANESTHETIC (1 OF 2)

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

VULVAR LICHEN SCLEROSUS / ITCHING – Cream (select one formula)	QUANTITY
☐ VUL-CLOB Clobetasol 0.05% vulvar cream	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ VUL-TAC Tacrolimus 0.03% vulvar cream	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ VUL-KNT Ketotifen 0.05% / naltrexone 0.5% / tacrolimus 0.03% vulvar cream	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ VUL-NAL Naltrexone 1% vaginal cream (itching)	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ VUL-KN Ketotifen 0.05% / naltrexone 1% vaginal cream (itching)	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ VUL-ESHA Estriol 0.3% / sodium hyaluronate vulvar cream	QTY: ☐ 30 ☐ 45 ☐ 60 gm
VAGINAL PROCEDURE ANESTHETIC (provider-applied; e.g. laser / MonaLisa Touch) (select one formula)	QUANTITY
☐ VPA-LT Lidocaine 23% / tetracaine 7% cream	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ VPA-BLT Benzocaine 20% / lidocaine 8% / tetracaine 4% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ VPA-LP Lidocaine 5% / prilocaine 5% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ gm

OFFICE USE – provider-applied or office-stocked items

Charge to: ☐ Patient ☐ Office Ship to: ☐ Patient ☐ Office ☐ Patient pick-up

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Apply a pea-sized amount to the affected area(s) twice daily.
☐ Provider applies to the vaginal/vulvar area 20–30 minutes before the procedure.
☐ Insert 1g vaginally _____ times 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

NEW PRESCRIPTION ORDER FORM – VULVAR CONDITIONS & PROCEDURE ANESTHETIC (2 OF 2)

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

PELVIC PAIN / VAGINISMUS – Vaginal Cream (see also Vulvodynia form) (select one formula)	QUANTITY
☐ VAG-AB Amitriptyline 2% / baclofen 2% vaginal cream	QTY: ☐ 30 ☐ 60 ☐ 15 gm/count
☐ VAG-AGL Amitriptyline 2% / gabapentin 6% / lidocaine 2% vaginal cream	QTY: ☐ 30 ☐ 60 ☐ 15 gm/count
☐ VAG-GL Gabapentin 6% / lidocaine 2.5% vaginal cream	QTY: ☐ 30 ☐ 60 ☐ 15 gm/count
☐ VAG-BDL Baclofen 2% / diazepam 1% / gabapentin 6% / lidocaine 2% vaginal cream (Schedule IV – EPCS only)	QTY: ☐ 30 ☐ 60 ☐ 15 gm/count
☐ VAG-DKL Diazepam 1% / ketamine 5% / lidocaine 5% vaginal cream (Schedule III – EPCS only)	QTY: ☐ 30 ☐ 60 ☐ 15 gm/count
☐ VAG-DBS Diazepam 5 mg / baclofen 10 mg vaginal suppository (Schedule IV – EPCS only)	QTY: ☐ 30 ☐ 60 ☐ 15 gm/count
CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ gm/count

OFFICE USE – provider-applied or office-stocked items

Charge to: ☐ Patient ☐ Office Ship to: ☐ Patient ☐ Office ☐ Patient pick-up

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Apply a pea-sized amount to the affected area(s) twice daily.
☐ Provider applies to the vaginal/vulvar area 20–30 minutes before the procedure.
☐ Insert 1g vaginally _____ times 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-RI-CR-40-15-1 section 1.3A10

NEW PRESCRIPTION ORDER FORM – ENDOMETRIOSIS, CERVICAL DYSPLASIA & NIPPLE CARE

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

ENDOMETRIOSIS / PROGESTERONE – Vaginal (select one formula)	QUANTITY
☐ END-DAN Danazol 10% vaginal gel	QTY: ☐ 30 ☐ 30 gm/count
☐ END-PRGS Progesterone 100 mg vaginal suppository	QTY: ☐ 30 ☐ 30 gm/count
☐ END-PRG200 Progesterone 200 mg vaginal suppository	QTY: ☐ 30 ☐ 30 gm/count
☐ END-PRGG Progesterone 10% vaginal gel	QTY: ☐ 30 ☐ 30 gm/count
CERVICAL DYSPLASIA – Topical Gel (provider – applied) (select one formula)	QUANTITY
☐ CVD-G20 Govey tincture 20% gel	QTY: ☐ 30 ☐ 60 gm
☐ CVD-G30 Govey tincture 30% gel	QTY: ☐ 30 ☐ 60 gm
NIPPLE CARE (BREASTFEEDING) – Ointment (select one formula)	QUANTITY
☐ APNO-STD All-purpose nipple ointment: mupirocin 1% / betamethasone 0.05% / miconazole 2%	QTY: ☐ 30 ☐ 60 gm
☐ APNO-NYS Mupirocin 1% / betamethasone 0.05% / nystatin 100,000 u/g ointment (miconazole-free)	QTY: ☐ 30 ☐ 60 gm
☐ APNO-LAN Lanolin 50% / lidocaine 2% nipple cream	QTY: ☐ 30 ☐ 60 gm
CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ gm

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Insert 1 suppository vaginally at bedtime.
☐ Apply sparingly to nipples after each feeding; do not wash off before the next feeding.
☐ Provider applies in office.
☐ 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 _____