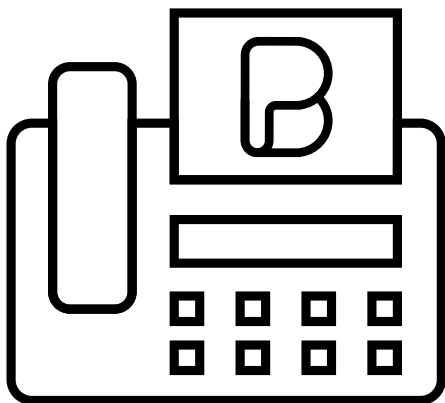




Your modern compounding pharmacy.™

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 – HEMORRHOIDS & ANAL FISSURES

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

ANAL FISSURES – Rectal Ointment (see also Anorectal Topicals form) (select one formula)	QUANTITY
☐ FIS-DL Diltiazem 2% / lidocaine 3% ointment	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count
☐ FIS-DL5 Diltiazem 2% / lidocaine 5% ointment	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count
☐ FIS-DLH Diltiazem 2% / lidocaine 2.5% / hydrocortisone 2.5% ointment	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count
☐ FIS-NL15 Nifedipine 0.3% / lidocaine 1.5% ointment	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count
☐ FIS-NL2 Nifedipine 0.2% / lidocaine 2% ointment	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count
☐ FIS-NTGL Nitroglycerin 0.125% / lidocaine 1% ointment	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count
☐ FIS-BD Bethanechol 0.1% / diltiazem 2% ointment	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count
☐ FIS-NS Nifedipine 0.2% suppository	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count
☐ FIS-DHL Diltiazem 3% / hydrocortisone 1% / lidocaine 2% suppository	QTY: ☐ 30 ☐ 45 ☐ 60 gm/count

Do not combine nitroglycerin with sildenafil, tadalafil or vardenafil.

HEMORRHOIDS – Ointment or Suppository (select one formula)	QUANTITY
☐ HEM-HL3S Hydrocortisone 2% / lidocaine 3% rectal rocket suppository	QTY: ☐ 30 ☐ 60 ☐ 5 gm/count
☐ HEM-HL1 Hydrocortisone 2% / lidocaine 1% ointment	QTY: ☐ 30 ☐ 60 ☐ 5 gm/count
☐ HEM-PZL Pramoxine 1% / zinc oxide 10.5% / lidocaine 5% ointment	QTY: ☐ 30 ☐ 60 ☐ 5 gm/count
☐ HEM-HL2S Hydrocortisone 1% / lidocaine 2% rectal rocket suppository	QTY: ☐ 30 ☐ 60 ☐ 5 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

- ☐ Apply a pea-sized amount to the anal area 2–3 times daily and after bowel movements.
- ☐ Insert 1 suppository rectally at bedtime for 5 nights.
- ☐ Apply a small amount into the rectum every 12 hours for up to 8 weeks.
- ☐ 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 – RECTAL SPASM, PELVIC FLOOR & SKIN

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

RECTAL / ANAL SPASM & PELVIC FLOOR – Suppository or Ointment (select one formula)	QUANTITY
☐ SPM-BGC Baclofen 20 mg / guaifenesin 50 mg / cyclobenzaprine 20 mg suppository	QTY: ☐ 15 ☐ 30 count
☐ SPM-BGCO Baclofen 2% / guaifenesin 5% / cyclobenzaprine 2% ointment	QTY: ☐ 15 ☐ 30 count
☐ SPM-BL Baclofen 10 mg / lidocaine 5% suppository (pelvic floor dysfunction)	QTY: ☐ 15 ☐ 30 count
☐ SPM-B10 Baclofen 10 mg suppository (vaginal or rectal)	QTY: ☐ 15 ☐ 30 count
☐ SPM-DB Diazepam 5 mg / baclofen 10 mg suppository (Schedule IV – EPCS only)	QTY: ☐ 15 ☐ 30 count
☐ SPM-D5 Diazepam 5 mg suppository (Schedule IV – EPCS only)	QTY: ☐ 15 ☐ 30 count
PERIANAL SKIN IRRITATION – Ointment (select one formula)	QUANTITY
☐ SKN-CHOL Cholestyramine 10% ointment	QTY: ☐ 30 ☐ 60 ☐ 120 gm
☐ SKN-CMM Cholestyramine 5% / mupirocin 0.5% / miconazole 0.5% ointment	QTY: ☐ 30 ☐ 60 ☐ 120 gm
☐ SKN-ZNC Zinc oxide 20% / nystatin 100,000 u/g / hydrocortisone 1% barrier cream	QTY: ☐ 30 ☐ 60 ☐ 120 gm
☐ SKN-MET Metronidazole 10% ointment (post-surgical)	QTY: ☐ 30 ☐ 60 ☐ 120 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 rectally at bedtime as needed for spasm.
☐ Apply a pea-sized amount to the anal area 2–3 times daily.
☐ Apply a thin layer to the affected skin after each bowel movement.
☐ 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 – IBD, PROCTITIS & COLITIS (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

RECTAL – Enemas (60 mL) (select one formula)	QUANTITY
☐ IBD-BUD2E Budesonide 2 mg / 60 mL enema	QTY: ☐ 14 ☐ 30 enemas
☐ IBD-MBE Mesalamine 4 g / budesonide 2 mg per 60 mL enema	QTY: ☐ 14 ☐ 30 enemas
☐ IBD-BBE Budesonide 1 mg / sodium butyrate 100 mM per 60 mL enema	QTY: ☐ 14 ☐ 30 enemas
☐ IBD-SBE Sodium butyrate 100 mM enema	QTY: ☐ 14 ☐ 30 enemas
☐ IBD-SCFA Short-chain fatty acid (acetate/propionate/butyrate 60/30/40 mM) enema	QTY: ☐ 14 ☐ 30 enemas
☐ IBD-SUC Sucralfate 40 mg/mL enema (radiation proctitis)	QTY: ☐ 14 ☐ 30 enemas
☐ IBD-TAC Tacrolimus 4 mg / 60 mL enema (resistant proctitis)	QTY: ☐ 14 ☐ 30 enemas
☐ IBD-VME Vancomycin 500 mg / metronidazole 250 mg per 60 mL enema (C. difficile)	QTY: ☐ 14 ☐ 30 enemas
RECTAL – Suppositories & Ointment (select one formula)	QUANTITY
☐ IBD-BUDS Budesonide 2 mg / 4 mg suppository (circle)	QTY: ☐ 14 ☐ 30 ☐ 60 count/gm
☐ IBD-MESS Mesalamine 250 / 500 / 750 / 900 mg suppository (circle)	QTY: ☐ 14 ☐ 30 ☐ 60 count/gm
☐ IBD-SBS Sodium butyrate 264 mg suppository	QTY: ☐ 14 ☐ 30 ☐ 60 count/gm
☐ IBD-TACS Tacrolimus 2 mg suppository	QTY: ☐ 14 ☐ 30 ☐ 60 count/gm
☐ IBD-TACO Tacrolimus 0.1% rectal ointment	QTY: ☐ 14 ☐ 30 ☐ 60 count/gm
CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____ QTY: _____ count/gm	
REFILLS (circle one)	
1 2 3 4 5 6 7 8 9 10 PRN NR	
DIRECTIONS/SIG + SIGNATURE	
☐ Administer one enema rectally at bedtime and retain overnight for _____ weeks.	
☐ Insert 1 suppository rectally _____ times daily.	
☐ Take _____ mL by mouth twice daily, slowly; nothing to eat or drink for 30 minutes after.	
☐ 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 – IBD, PROCTITIS & COLITIS (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

ORAL (select one formula)	QUANTITY
☐ IBD-BUD1 Budesonide 1mg / 10 mL oral suspension	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ IBD-BUDG Budesonide 2 mg / 10 mL oral viscous gel	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ IBD-MESL Mesalamine 50 mg/mL oral liquid	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ IBD-LDN Low dose naltrexone 1.5 / 3 / 4.5 mg capsule (circle)	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
☐ IBD-VAN Vancomycin 20 mg/mL oral solution (C. difficile) - flavor: _____	QTY: ☐ 30 ☐ 90 ☐ 240 mL/caps
CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ mL/caps
REFILLS (circle one)	
1 2 3 4 5 6 7 8 9 10 PRN NR	
DIRECTIONS/SIG + SIGNATURE	
☐ Administer one enema rectally at bedtime and retain overnight for _____ weeks.	
☐ Insert 1 suppository rectally _____ times daily.	
☐ Take _____ mL by mouth twice daily, slowly; nothing to eat or drink for 30 minutes after.	
☐ Other _____	
X _____	_____
Prescriber's Signature	Date

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

Pharmacy Name

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Pharmacy Fax Number

NEW PRESCRIPTION ORDER FORM – REFLUX, GASTROPARESIS & EOSINOPHILIC ESOPHAGITIS (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

REFLUX – PPI Oral Suspensions (flavor: cherry / strawberry / watermelon / banana / flavorless) (select one formula) QUANTITY

☐ RFX-OME Omeprazole ____ mg/mL oral suspension (2 - 10 mg/mL)	QTY: ☐ 90 ☐ 150 ☐ 300 mL
☐ RFX-ESO Esomeprazole 2 mg/mL oral suspension	QTY: ☐ 90 ☐ 150 ☐ 300 mL
☐ RFX-LAN Lansoprazole ____ mg/mL oral suspension (3 - 10 mg/mL)	QTY: ☐ 90 ☐ 150 ☐ 300 mL
☐ RFX-PAN Pantoprazole 2 mg/mL or 4 mg/mL oral suspension (circle)	QTY: ☐ 90 ☐ 150 ☐ 300 mL

EOSINOPHILIC ESOPHAGITIS / COLITIS – Oral Suspension (select one formula) QUANTITY

☐ EOE-BUD1 Budesonide 1 mg / 5 mL oral viscous suspension	QTY: ☐ 150 ☐ 300 mL
☐ EOE-BUD2 Budesonide 2 mg / 5 mL oral viscous suspension	QTY: ☐ 150 ☐ 300 mL
☐ EOE-MKB Montelukast 1 mg/mL / ketotifen 0.5 mg/mL / budesonide 0.5 mg/mL oral suspension	QTY: ☐ 150 ☐ 300 mL
☐ EOE-MKBQ Montelukast 1 mg/mL / ketotifen 0.5 mg/mL / budesonide 0.5 mg/mL / quercetin 10 mg/mL oral suspension	QTY: ☐ 150 ☐ 300 mL
☐ EOE-FLU Fluticasone 3 mg / 5 mL oral viscous suspension	QTY: ☐ 150 ☐ 300 mL

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

☐ _____	QTY: _____ mL
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REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Take _____ mL by mouth _____ times daily.
☐ Take 5 mL by mouth twice daily; swallow slowly and do not eat or drink for 30 minutes after.
☐ Take 1 capsule by mouth 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
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NEW PRESCRIPTION ORDER FORM – REFLUX, GASTROPARESIS & EOSINOPHILIC ESOPHAGITIS (2 OF 2)

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

GASTROPARESIS / IBS – Capsules (select one formula)	QUANTITY
☐ GAS-N15 Naltrexone 1.5 mg capsule	QTY: ☐ 30 ☐ 90 caps
☐ GAS-N45 Naltrexone 4.5 mg capsule	QTY: ☐ 30 ☐ 90 caps
☐ GAS-N05 Naltrexone 0.5 mg capsule (IBS)	QTY: ☐ 30 ☐ 90 caps
☐ GAS-CIS Cisapride 5 mg/mL oral suspension (human use - call pharmacy)	QTY: ☐ 30 ☐ 90 caps
CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ caps
REFILLS (circle one)	
1 2 3 4 5 6 7 8 9 10 PRN NR	
DIRECTIONS/SIG + SIGNATURE	
☐ Take _____ mL by mouth _____ times daily.	
☐ Take 5 mL by mouth twice daily; swallow slowly and do not eat or drink for 30 minutes after.	
☐ Take 1 capsule by mouth 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 _____ Pharmacy Fax Number _____

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