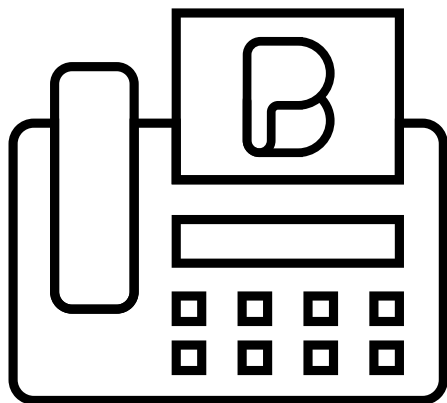




Your modern compounding pharmacy.™

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 – HAIR LOSS (MEN) (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

MEN – Topical Scalp Solution or Foam (select one formula)	QUANTITY
☐ HLM-MF5 Minoxidil 5% / finasteride 0.1% solution	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLM-MT2 Minoxidil 2% / tretinoin 0.025% solution (mild)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLM-MF3 Minoxidil 3% / finasteride 0.25% solution (mild)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLM-MDT Minoxidil 5% / dutasteride 0.05% / tretinoin 0.025% solution (moderate)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLM-MAD Minoxidil 5% / azelaic acid 1.5% / dutasteride 0.05% foam (moderate)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLM-MFTF Minoxidil 10% / finasteride 0.1% / tretinoin 0.025% / fluocinolone 0.025% solution	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLM-MBF Minoxidil 10% / biotin 0.2% / finasteride 0.1% solution (severe)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLM-M15 Minoxidil 15% foam (severe)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLM-MTC Minoxidil 5% / tacrolimus 0.3% / clobetasol 0.05% foam (inflammatory / alopecia areata)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
MEN – Oral Capsules (select one formula)	QUANTITY
☐ HLM-C25 Minoxidil 0.25 mg / finasteride 1mg capsule (mild)	QTY: ☐ 30 ☐ 90 caps
☐ HLM-C5 Minoxidil 0.5 mg / finasteride 1mg capsule (moderate)	QTY: ☐ 30 ☐ 90 caps
☐ HLM-C1 Minoxidil 1mg / finasteride 1mg capsule (severe)	QTY: ☐ 30 ☐ 90 caps
☐ HLM-C51 Minoxidil 5 mg / finasteride 1mg capsule	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

☐ Apply 1mL to the dry scalp once daily at bedtime.

☐ Apply 1mL (2 pumps) to the scalp twice daily.

☐ Take 1 capsule by mouth once 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 – HAIR LOSS (MEN) (2 OF 2)

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

SHAMPOO (select one formula)	QUANTITY
☐ HL-KET Ketoconazole 2% shampoo	QTY: ☐ 120 ☐ 240 mL
☐ HL-ZPC Zinc pyrithione 0.25% / clobetasol 0.05% scalp spray	QTY: ☐ 120 ☐ 240 mL
CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ mL
REFILLS (circle one)	
1 2 3 4 5 6 7 8 9 10 PRN NR	
DIRECTIONS/SIG + SIGNATURE	
☐ Apply 1mL to the dry scalp once daily at bedtime.	
☐ Apply 1mL (2 pumps) to the scalp twice daily.	
☐ Take 1 capsule by mouth once 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 – HAIR LOSS (WOMEN)

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

WOMEN – Topical Scalp Solution or Foam (select one formula)	QUANTITY
☐ HLW-MT2 Minoxidil 2% / tretinoin 0.025% solution (mild)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-MT1 Minoxidil 1% / tretinoin 0.025% gel (mild, sensitive)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-MFT Minoxidil 5% / finasteride 0.1% / tretinoin 0.025% solution	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-MFTS Minoxidil 6% / finasteride 0.1% / tretinoin 0.0125% / spironolactone 0.25% solution	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-MTS Minoxidil 6% / tretinoin 0.01% / spironolactone 0.5% solution (moderate)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-MPT Minoxidil 5% / progesterone 0.25% / tretinoin 0.025% solution	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-MPS Minoxidil 5% / progesterone 0.25% / spironolactone 3% foam	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-ME Minoxidil 5% / estradiol 0.025% gel	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-MT8 Minoxidil 8% / tretinoin 0.01% solution (severe)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-MF10 Minoxidil 10% / finasteride 0.1% solution (severe)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
WOMEN – Oral (select one formula)	QUANTITY
☐ HLW-MS25 Minoxidil 0.25 mg / spironolactone 25 mg capsule	QTY: ☐ 30 ☐ 90 caps/mL
☐ HLW-MS5 Minoxidil 0.5 mg / spironolactone 25 mg capsule	QTY: ☐ 30 ☐ 90 caps/mL
☐ HLW-M125 Minoxidil 0.125 mg capsule (low-dose oral minoxidil)	QTY: ☐ 30 ☐ 90 caps/mL
☐ HLW-MSOL Minoxidil 2.5 mg/mL oral solution	QTY: ☐ 30 ☐ 90 caps/mL
CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ caps/mL

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Apply 1 mL to the dry scalp once daily at bedtime.
☐ Take 1 capsule by mouth once daily.
☐ Take _____ mL by mouth once 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-RCR-40-15-1 section 1.3A10

Pharmacy Fax Number