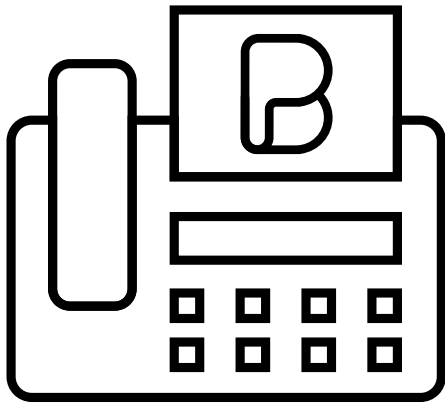




Your modern compounding pharmacy.™

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 – SINUS IRRIGATION & NASAL SPRAYS (1 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

SINUS IRRIGATION CAPSULES (dissolve 1 capsule in 240 mL saline rinse) (select one formula)	QUANTITY
☐ SNS-BUD06 Budesonide 0.6 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-BUD1 Budesonide 1mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-MOM Mometasone 0.6 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-MUP Mupirocin 15 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-GEN Gentamicin 80 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-VAN Vancomycin 200 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-LEV Levofloxacin 100 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-CLI Clindamycin 50 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-AMB Amphotericin B 5 mg /10 mg capsule (circle)	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-ITR Itraconazole 40 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-BIO Mupirocin 30 mg / edetate disodium 15 mg / gentamicin 80 mg capsule (biofilm)	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ SNS-BUDABX Budesonide 0.6 mg + _____ mg combination capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps

Capsules can also be nebulized: dissolve 1 capsule in 15 mL saline and nebulize into both nostrils twice daily.

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
☐ Dissolve contents of 1 capsule in 240 mL saline; irrigate half per nostril twice daily.
☐ Spray once in each nostril twice daily.
☐ Spray _____ time(s) in each nostril _____ times daily as needed.
☐ 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 – SINUS IRRIGATION & NASAL SPRAYS (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

NASAL SPRAYS (select one formula)	QUANTITY
☐ NAS-MUP Mupirocin 0.2% nasal spray	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ NAS-LID4 Lidocaine 4% nasal spray (headache / procedures)	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ NAS-KET Ketoconazole 2% nasal spray	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ NAS-GLU Glutathione 125 mg/mL nasal spray	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ NAS-IVM Ivermectin 1 mg / 0.1 mL nasal spray	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ NAS-BIO Gentamicin 0.008% / mupirocin 0.2% / edetate disodium 0.1% nasal spray (biofilm)	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ NAS-TXA Tranexamic acid 5% / 10% nasal spray (nosebleeds, circle)	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ NAS-CM Camphor 0.2% / menthol 0.2% in mineral oil nasal spray (dryness)	QTY: ☐ 10 ☐ 15 ☐ 30 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
☐ Dissolve contents of 1 capsule in 240 mL saline; irrigate half per nostril twice daily.
☐ Spray once in each nostril twice daily.
☐ Spray _____ time(s) in each nostril _____ times daily as needed.
☐ 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 – EAR, THROAT & MOUTH (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

OTIC SOLUTIONS (select one formula)	QUANTITY
☐ OTC-BNZ10 Benzocaine 10% otic solution	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ OTC-BNZ20 Benzocaine 20% otic solution	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ OTC-TET30 Tetracaine 30% otic solution	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ OTC-DOC Docusate sodium 2% otic solution (ear wax softening)	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ OTC-TRO Trolamine oleate otic solution (ear wax softening)	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ OTC-VAN Vancomycin 25 mg/mL otic solution	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ OTC-TAC Tacrolimus 0.1% otic solution	QTY: ☐ 10 ☐ 15 ☐ 30 mL

THROAT – Popsicles, Rinses & Lozenges (select one formula)	QUANTITY
☐ THR-TETP Tetracaine 0.025% popsicle	QTY: ☐ 12 ☐ 30 ☐ 240 count/mL
☐ THR-LIDP Lidocaine 2% popsicle	QTY: ☐ 12 ☐ 30 ☐ 240 count/mL
☐ THR-IBUP Ibuprofen 100 mg popsicle	QTY: ☐ 12 ☐ 30 ☐ 240 count/mL
☐ THR-LIDR Lidocaine 2% oral rinse	QTY: ☐ 12 ☐ 30 ☐ 240 count/mL
☐ THR-MEN Menthol 0.3% oral solution (instant voice)	QTY: ☐ 12 ☐ 30 ☐ 240 count/mL
☐ THR-PIL Pilocarpine 10 mg/mL oral solution (dry mouth)	QTY: ☐ 12 ☐ 30 ☐ 240 count/mL
☐ THR-PILL Pilocarpine 2 mg / 4 mg lozenge (dry mouth, circle)	QTY: ☐ 12 ☐ 30 ☐ 240 count/mL

CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ count/mL

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Instill _____ drops in the affected ear _____ times daily.
☐ Place _____ drops under the tongue _____ times daily for excess secretions.
☐ Apply 0.25 mL to the inner wrist every _____ hours as needed.
☐ 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

NEW PRESCRIPTION ORDER FORM – EAR, THROAT & MOUTH (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

SIALORRHEA (EXCESS SECRETIONS) & NAUSEA (select one formula)	QUANTITY
☐ SIA-ATR Atropine 1% sublingual drops	QTY: ☐ 15 ☐ 30 ☐ 60 mL/gm/count
☐ SIA-GLYS Glycopyrrolate 0.5 mg/mL oral suspension	QTY: ☐ 15 ☐ 30 ☐ 60 mL/gm/count
☐ SIA-GLYT Glycopyrrolate 0.1 mg / 0.25 mL topical cream	QTY: ☐ 15 ☐ 30 ☐ 60 mL/gm/count
☐ SIA-SCO Scopolamine 0.25 mg / 0.1 mL topical cream	QTY: ☐ 15 ☐ 30 ☐ 60 mL/gm/count
☐ NAU-OND Ondansetron 4 mg / 0.1 mL topical cream	QTY: ☐ 15 ☐ 30 ☐ 60 mL/gm/count
☐ NAU-PRO Promethazine 25 mg/g topical cream	QTY: ☐ 15 ☐ 30 ☐ 60 mL/gm/count
☐ NAU-DPS Doxylamine 10 mg / pyridoxine 10 mg suppository	QTY: ☐ 15 ☐ 30 ☐ 60 mL/gm/count
☐ NAU-DPG Doxylamine 10 mg / pyridoxine 10 mg / ginger root capsule	QTY: ☐ 15 ☐ 30 ☐ 60 mL/gm/count
CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ mL/gm/count

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Instill _____ drops in the affected ear _____ times daily.
☐ Place _____ drops under the tongue _____ times daily for excess secretions.
☐ Apply 0.25 mL to the inner wrist every _____ hours as needed.
☐ Other _____
X _____
Prescriber's Signature _____ Date _____

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Pharmacy Name

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Pharmacy Fax Number