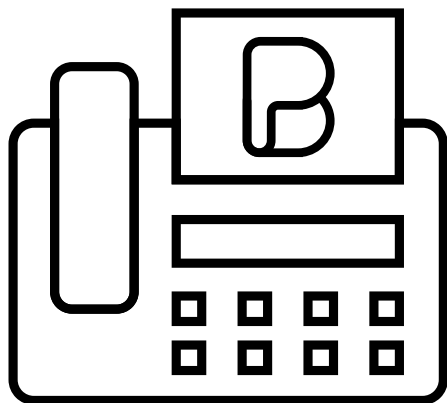




Your modern compounding pharmacy.™

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 – WARTS & MOLLUSCUM (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

PROVIDER – APPLIED (in office only) – Topical Liquid (select one)	QUANTITY
☐ WRT-CPS30 Cantharidin 1% / podophyllin 5% / salicylic acid 30% liquid	QTY: ☐ 5 ☐ 10 mL
☐ WRT-CPS25 Cantharidin 1% / podophyllin 5% / salicylic acid 25% liquid	QTY: ☐ 5 ☐ 10 mL
☐ WRT-CS30 Cantharidin 1% / salicylic acid 30% liquid	QTY: ☐ 5 ☐ 10 mL
☐ WRT-CAN1 Cantharidin 1% liquid (molluscum)	QTY: ☐ 5 ☐ 10 mL
☐ WRT-SPT Salicylic acid 10% / podophyllin 10% / trichloroacetic acid 10% solution	QTY: ☐ 5 ☐ 10 mL
PATIENT – APPLIED – Topical (select one formula)	QUANTITY
☐ WRT-SQ1 Squaric acid dibutyl ester 0.1% solution	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
☐ WRT-SQ2 Squaric acid dibutyl ester 0.2% solution	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
☐ WRT-SA40 Salicylic acid 40% ointment	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
☐ WRT-SAI7 Salicylic acid 16.7% in flexible collodion	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
☐ WRT-IMQ5 Imiquimod 5% cream	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
☐ WRT-CDI Cimetidine 10% / deoxy-D-glucose 0.2% / ibuprofen 2% cream	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
☐ WRT-CIM Cimetidine 60 mg/mL oral suspension	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
CUSTOM – (other formula or strength – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ gm/mL

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

☐ Provider applies to lesion(s) in office; wash off after _____ hours.

☐ Apply to wart(s) twice daily; cover as directed.

☐ Apply 3 nights per week at bedtime; wash off in the morning.

☐ 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 – WARTS & MOLLUSCUM (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

GENITAL WARTS – Vaginal / Rectal (select one formula)	QUANTITY
☐ GWT-IMQ05 Imiquimod 0.5% vaginal gel	QTY: ☐ 30 ☐ 14 gm/count
☐ GWT-IMQS Imiquimod 6 mg suppository	QTY: ☐ 30 ☐ 14 gm/count
☐ GWT-DAI Deoxy-D-glucose 0.2% / acyclovir 5% / imiquimod 2.5% / tea tree oil 2.5% vaginal gel	QTY: ☐ 30 ☐ 14 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	
☐ Provider applies to lesion(s) in office; wash off after _____ hours.	
☐ Apply to wart(s) twice daily; cover as directed.	
☐ Apply 3 nights per week at bedtime; wash off in the morning.	
☐ 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