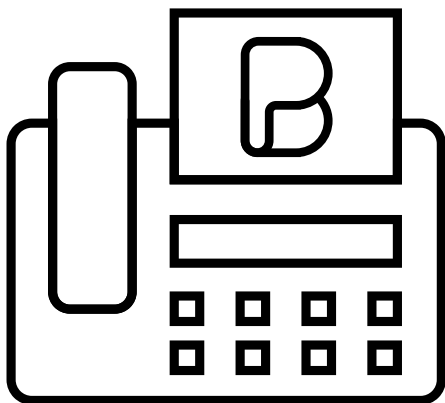




Your modern compounding pharmacy.™

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 – MELOXICAM – TOPICALS

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

SINGLE AGENT & TIZANIDINE (15 mg/mL gel is dispensed by mL) QUANTITY

☐ MLX-G15 Meloxicam 15 mg/mL topical gel	QTY: ☐ 30 ☐ 60 ☐ 120 g
☐ MLX-CTZ Meloxicam 0.3% / Tizanidine HCl 0.2% topical cream	QTY: ☐ 30 ☐ 60 ☐ 120 g
☐ MLX-LTZ Lidocaine 1.042% / Meloxicam 0.1% / Tizanidine HCl 0.4% topical cream	QTY: ☐ 30 ☐ 60 ☐ 120 g

WITH GABAPENTIN OR AMITRIPTYLINE QUANTITY

☐ MLX-GAB Gabapentin 6% / Meloxicam 0.5% topical gel	QTY: ☐ 30 ☐ 60 ☐ 120 g
☐ MLX-GLP Gabapentin 6% / Lidocaine 2% / Prilocaine HCl 2% / Meloxicam 0.09% topical gel	QTY: ☐ 30 ☐ 60 ☐ 120 g
☐ MLX-AL Amitriptyline HCl 1% / Lidocaine HCl 2.5% / Meloxicam 0.1% topical gel	QTY: ☐ 30 ☐ 60 ☐ 120 g
☐ MLX-AGLT Amitriptyline 2.5% / Gabapentin 3% / Lidocaine 4.44% / Meloxicam 0.5% / Topiramate 1.25% oint.	QTY: ☐ 30 ☐ 60 ☐ 120 g

WITH LIDOCAINE & TOPIRAMATE QUANTITY

☐ MLX-LT Lidocaine HCl 5% / Meloxicam 0.3% / Topiramate 3% topical cream	QTY: ☐ 30 ☐ 60 ☐ 120 g
☐ MLX-LPTC Lidocaine 2% / Meloxicam 0.09% / Prilocaine 2% / Topiramate 2.5% topical cream	QTY: ☐ 30 ☐ 60 ☐ 120 g
☐ MLX-LPTG Lidocaine 2% / Meloxicam 0.09% / Prilocaine 2% / Topiramate 2.5% transdermal gel	QTY: ☐ 30 ☐ 60 ☐ 120 g

No meloxicam topical is FDA-approved; topical and combination preparations are compounded and off-label. Tramadol-containing combinations are Schedule IV and must be e-prescribed (EPCS), not faxed.

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

☐ _____	QTY: _____ g
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CONTAINER (gel / cream / ointment)

☐ Metered pump	☐ Jar	☐ Tube	☐ Pump supplied if left blank
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REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Apply _____ g (or _____ pump clicks) to the affected area _____ times daily. Intact skin only; do not occlude.
☐ Apply a thin layer to the affected area as directed, no more than _____ times daily. Do not use with another NSAID.
☐ 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 – MELOXICAM – ORAL

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

TABLET **QUANTITY**

☐ **MLX-T3** Meloxicam 3 mg oral tablet QTY: ☐ 30 ☐ 60 ☐ 90 tabs

ORAL LIQUID **QUANTITY**

☐ **MLX-L1** Meloxicam 1 mg/mL oral liquid QTY: ☐ 15 ☐ 30 ☐ 60 ☐ 120 mL

☐ **MLX-L15** Meloxicam 1.5 mg/mL oral liquid QTY: ☐ 15 ☐ 30 ☐ 60 ☐ 120 mL

☐ **MLX-L3** Meloxicam 3 mg/mL oral liquid QTY: ☐ 15 ☐ 30 ☐ 60 ☐ 120 mL

☐ **MLX-L5** Meloxicam 5 mg/mL oral liquid QTY: ☐ 15 ☐ 30 ☐ 60 ☐ 120 mL

☐ **MLX-L30** Meloxicam 30 mg/mL oral liquid QTY: ☐ 15 ☐ 30 ☐ 60 ☐ 120 mL

Manufactured meloxicam 7.5 mg and 15 mg tablets and 7.5 mg/5 mL oral suspension are FDA-approved; order those as such unless a compounded strength or form is required. Veterinary meloxicam: use the Veterinary order form.

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

☐ Take _____ tablet(s) by mouth once daily with food.

☐ Take _____ mL by mouth once daily with food. Measure each dose with the oral syringe provided.

☐ 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