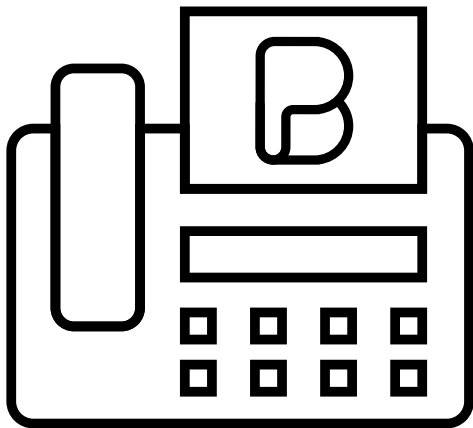




Your modern compounding pharmacy.™

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# FAX COVER SHEET



Please fax your order to:

**401-284-4506**

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3844 Post Road, Warwick RI 02886

Phone: 401 - 284 - 4505

[www.bayviewrx.com](http://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](http://www.bayviewrx.com)



**Your modern compounding pharmacy. <sup>TM</sup>**

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.

|                      |                                   |
|----------------------|-----------------------------------|
| <b>Pharmacy Name</b> | Bayview Pharmacy                  |
| <b>Address</b>       | 3844 Post Road, Warwick, RI 02886 |
| <b>NCPDP ID</b>      | 4106882                           |
| <b>NPI</b>           | 1750455143                        |
| <b>Phone</b>         | (401) 284-4505                    |
| <b>Fax</b>           | (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](http://www.bayviewrx.com)

# NEW PRESCRIPTION ORDER FORM – VET 1/4: CARDIOVASCULAR

## 1 Patient (Pet) and Owner Information

|                 |                                                                                         |                               |                                                          |
|-----------------|-----------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------|
| Pet Name        | Species <input type="radio"/> Dog <input type="radio"/> Cat <input type="radio"/> Other | Breed                         | Weight <input type="radio"/> lb <input type="radio"/> kg |
| Owner Last Name | Owner First Name                                                                        | Pet Date of Birth or Age      |                                                          |
| Address         |                                                                                         |                               | Apt. #                                                   |
| City            | State                                                                                   | ZIP                           | Owner Phone                                              |
| Owner Email     |                                                                                         | Allergies / other medications |                                                          |

## 2 Veterinarian Information

|                     |                                    |
|---------------------|------------------------------------|
| Veterinarian's Name | Clinic or Hospital                 |
| Phone Number        | Fax Number                         |
| Street Address      |                                    |
| City                | State ZIP                          |
| State License #     | DEA (controlled only) NPI (if any) |

## 3 Medication Selection

| HEART DISEASE & BLOOD PRESSURE (select one)                                                                                  | QUANTITY                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>VET-PIM</b> Pimobendan 1.25 / 1.5 / 2 / 2.5 / 3 / 4 / 10 mg/mL flavored oral suspension (circle) | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 mL |
| <input type="checkbox"/> <b>VET-PIMC</b> Pimobendan 2.5 / 10 / 15 mg capsules (circle)                                       | QTY: <input type="checkbox"/> 60 <input type="checkbox"/> 100 caps                          |
| <input type="checkbox"/> <b>VET-PIMS</b> Pimobendan 2 mg/mL + sildenafil 10 mg/mL oral suspension                            | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 mL |
| <input type="checkbox"/> <b>VET-ATEN</b> Atenolol 6.25 mg per 0.1 mL transdermal ear gel, TopiClick                          | QTY: <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 9 mL    |
| <input type="checkbox"/> <b>VET-AML</b> Amlodipine 2.5 mg/mL flavored oral suspension                                        | QTY: <input type="checkbox"/> 15 <input type="checkbox"/> 30 mL                             |
| <input type="checkbox"/> <b>VET-BEN</b> Benazepril 4 / 5 mg/mL oral suspension (circle)                                      | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 mL                             |
| <input type="checkbox"/> <b>VET-BENC</b> Benazepril 2.5 mg capsules                                                          | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 caps                           |
| <input type="checkbox"/> <b>VET-ENA</b> Enalapril 3 / 10 mg/mL oral suspension (circle)                                      | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 mL                             |
| <input type="checkbox"/> <b>VET-CLO</b> Clopidogrel 75 mg/mL oral suspension                                                 | QTY: <input type="checkbox"/> 15 <input type="checkbox"/> 30 mL                             |
| <input type="checkbox"/> <b>VET-FUR</b> Furosemide 12 / 25 mg/mL oral suspension (circle)                                    | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 mL                             |
| <input type="checkbox"/> <b>VET-SPI</b> Spironolactone 3 / 10 mg/mL oral suspension (circle)                                 | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 mL                             |
| <input type="checkbox"/> <b>VET-BCF</b> Benazepril 2.5 / clopidogrel 37.5 / furosemide 10 mg/mL oral suspension              | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 mL                             |
| CUSTOM – (other formula or strength – call pharmacy to confirm)                                                              | QUANTITY                                                                                    |
| <input type="checkbox"/> _____                                                                                               | QTY: _____ mL                                                                               |

### FLAVOR (liquids)

☐ Chicken ☐ Fish ☐ Tuna ☐ Beef ☐ Pharmacy choice if left blank

### REFILLS (circle one)

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

### DIRECTIONS/SIG + SIGNATURE

|                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Give _____ mL or _____ capsule(s) by mouth every _____ hours.                                             |
| <input type="checkbox"/> Apply _____ click(s) ( _____ mg) to the inner ear pinna every _____ hours, alternating ears; wear gloves. |
| <input type="checkbox"/> Other _____                                                                                               |
| X _____<br>Veterinarian'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 – VET 2/4: THYROID & BEHAVIOR

## 1 Patient (Pet) and Owner Information

|                 |                                                                                         |                               |                                                          |
|-----------------|-----------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------|
| Pet Name        | Species <input type="radio"/> Dog <input type="radio"/> Cat <input type="radio"/> Other | Breed                         | Weight <input type="radio"/> lb <input type="radio"/> kg |
| Owner Last Name | Owner First Name                                                                        | Pet Date of Birth or Age      |                                                          |
| Address         |                                                                                         |                               | Apt. #                                                   |
| City            | State                                                                                   | ZIP                           | Owner Phone                                              |
| Owner Email     |                                                                                         | Allergies / other medications |                                                          |

## 2 Veterinarian Information

|                     |                                    |
|---------------------|------------------------------------|
| Veterinarian's Name | Clinic or Hospital                 |
| Phone Number        | Fax Number                         |
| Street Address      |                                    |
| City                | State ZIP                          |
| State License #     | DEA (controlled only) NPI (if any) |

## 3 Medication Selection

| HYPERTHYROIDISM (CATS) (select one)                                                                                       | QUANTITY                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>VET-MET</b> Methimazole 2.5 / 5 / 10 mg/mL flavored oral suspension (circle)                  | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 mL   |
| <input type="checkbox"/> <b>VET-METT</b> Methimazole 1.25 / 2.5 / 5 mg per 0.1 mL transdermal ear gel, TopiClick (circle) | QTY: <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 9 mL      |
| <input type="checkbox"/> <b>VET-METTC</b> Methimazole ____ mg per 0.1 mL transdermal ear gel (custom strength)            | QTY: <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 9 mL      |
| ANXIETY & BEHAVIOR (select one)                                                                                           | QUANTITY                                                                                      |
| <input type="checkbox"/> <b>VET-FLX</b> Fluoxetine 2.5 / 3 / 4 / 5 mg capsules (circle)                                   | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 caps                             |
| <input type="checkbox"/> <b>VET-FLXL</b> Fluoxetine 12 mg/mL flavored oral suspension                                     | QTY: <input type="checkbox"/> 15 <input type="checkbox"/> 30 mL                               |
| <input type="checkbox"/> <b>VET-TRAZ</b> Trazodone 50 / 100 mg/mL flavored oral suspension (circle)                       | QTY: <input type="checkbox"/> 3 <input type="checkbox"/> 15 <input type="checkbox"/> 30 mL    |
| <input type="checkbox"/> <b>VET-TRAZT</b> Trazodone 100 mg/g transdermal ear gel, TopiClick                               | QTY: <input type="checkbox"/> 6 <input type="checkbox"/> 15 g                                 |
| <input type="checkbox"/> <b>VET-AMIT</b> Amitriptyline 5 / 10 mg per 0.1 mL transdermal ear gel, TopiClick (circle)       | QTY: <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 9 mL      |
| <input type="checkbox"/> <b>VET-GAB</b> Gabapentin 100 / 300 mg/mL flavored oral suspension (circle)                      | QTY: <input type="checkbox"/> 10 <input type="checkbox"/> 30 <input type="checkbox"/> 60 mL   |
| <input type="checkbox"/> <b>VET-GABC</b> Gabapentin 45 mg capsules                                                        | QTY: <input type="checkbox"/> 21 <input type="checkbox"/> 30 <input type="checkbox"/> 60 caps |
| <input type="checkbox"/> <b>VET-GABT</b> Gabapentin 40 mg per 0.1 mL transdermal ear gel, TopiClick                       | QTY: <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 9 mL      |
| CUSTOM – (other formula or strength – call pharmacy to confirm)                                                           | QUANTITY                                                                                      |
| <input type="checkbox"/> _____                                                                                            | QTY: _____ mL                                                                                 |

### FLAVOR (liquids)

☐ Chicken ☐ Fish ☐ Tuna ☐ Beef ☐ Pharmacy choice if left blank

### REFILLS (circle one)

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

### DIRECTIONS/SIG + SIGNATURE

|                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Give _____ mL or _____ capsule(s) by mouth every _____ hours.                                             |
| <input type="checkbox"/> Give _____ mL by mouth _____ minutes before the stressful event, as needed.                               |
| <input type="checkbox"/> Apply _____ click(s) ( _____ mg) to the inner ear pinna every _____ hours, alternating ears; wear gloves. |
| <input type="checkbox"/> Other _____                                                                                               |
| X _____                                                                                                                            |
| Veterinarian'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 – VET 3/4: SEIZURES & URINARY

## 1 Patient (Pet) and Owner Information

|                 |                                                                                         |                               |                                                          |
|-----------------|-----------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------|
| Pet Name        | Species <input type="radio"/> Dog <input type="radio"/> Cat <input type="radio"/> Other | Breed                         | Weight <input type="radio"/> lb <input type="radio"/> kg |
| Owner Last Name | Owner First Name                                                                        | Pet Date of Birth or Age      |                                                          |
| Address         |                                                                                         |                               | Apt. #                                                   |
| City            | State                                                                                   | ZIP                           | Owner Phone                                              |
| Owner Email     |                                                                                         | Allergies / other medications |                                                          |

## 2 Veterinarian Information

|                     |                                    |
|---------------------|------------------------------------|
| Veterinarian's Name | Clinic or Hospital                 |
| Phone Number        | Fax Number                         |
| Street Address      |                                    |
| City                | State ZIP                          |
| State License #     | DEA (controlled only) NPI (if any) |

## 3 Medication Selection

| SEIZURES & EPILEPSY (select one)                                                                      | QUANTITY                                                                                     |
|-------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>VET-LEV</b> Levetiracetam 100 mg/mL oral suspension                       | QTY: <input type="checkbox"/> 60 <input type="checkbox"/> 160 mL                             |
| <input type="checkbox"/> <b>VET-ZON</b> Zonisamide 20 / 50 mg/mL oral suspension (circle)             | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 mL                              |
| <input type="checkbox"/> <b>VET-KBR</b> Potassium bromide 250 mg/mL oral solution (dogs only)         | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 120 mL |
| <input type="checkbox"/> <b>VET-KBRC</b> Potassium bromide 500 / 750 mg capsules (dogs only) (circle) | QTY: <input type="checkbox"/> 90 <input type="checkbox"/> 180 caps                           |

Gabapentin as a seizure add-on: order it from the Anxiety & Behavior section above (VET-GAB).

| URINARY INCONTINENCE & STONES (select one)                                                                           | QUANTITY                                                                                      |
|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>VET-PPA</b> Phenylpropanolamine HCl 10 / 25 / 50 mg/mL flavored oral suspension (circle) | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 mL                               |
| <input type="checkbox"/> <b>VET-KCIT</b> Potassium citrate 500 mg/mL oral solution                                   | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 120 <input type="checkbox"/> 420 mL |
| <input type="checkbox"/> <b>VET-PRAZ</b> Prazosin 1 mg/mL oral suspension                                            | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 mL                               |

| CUSTOM – (other formula or strength – call pharmacy to confirm) | QUANTITY      |
|-----------------------------------------------------------------|---------------|
| <input type="checkbox"/> _____                                  | QTY: _____ mL |

### FLAVOR (liquids)

☐ Chicken ☐ Fish ☐ Tuna ☐ Beef ☐ Pharmacy choice if left blank

### REFILLS (circle one)

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

### DIRECTIONS/SIG + SIGNATURE

|                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Give _____ mL or _____ capsule(s) by mouth every _____ hours.                                             |
| <input type="checkbox"/> Apply _____ click(s) ( _____ mg) to the inner ear pinna every _____ hours, alternating ears; wear gloves. |
| <input type="checkbox"/> Other _____                                                                                               |
| X _____                                                                                                                            |
| Veterinarian'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 – VET 4/4: INFLAMMATION & GI

## 1 Patient (Pet) and Owner Information

|                 |                                                                                         |                               |                                                          |
|-----------------|-----------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------|
| Pet Name        | Species <input type="radio"/> Dog <input type="radio"/> Cat <input type="radio"/> Other | Breed                         | Weight <input type="radio"/> lb <input type="radio"/> kg |
| Owner Last Name | Owner First Name                                                                        | Pet Date of Birth or Age      |                                                          |
| Address         |                                                                                         |                               | Apt. #                                                   |
| City            | State                                                                                   | ZIP                           | Owner Phone                                              |
| Owner Email     |                                                                                         | Allergies / other medications |                                                          |

## 2 Veterinarian Information

|                     |                                    |
|---------------------|------------------------------------|
| Veterinarian's Name | Clinic or Hospital                 |
| Phone Number        | Fax Number                         |
| Street Address      |                                    |
| City                | State ZIP                          |
| State License #     | DEA (controlled only) NPI (if any) |

## 3 Medication Selection

| ALLERGIES, INFLAMMATION & IBD (select one)                                                              | QUANTITY                                                                                      |
|---------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>VET-PRED</b> Prednisolone 5 / 10 mg/mL flavored oral suspension (circle)    | QTY: <input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> 30 mL   |
| <input type="checkbox"/> <b>VET-PREDT</b> Prednisolone 7 mg per 0.1 mL transdermal ear gel, TopiClick   | QTY: <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 9 mL      |
| <input type="checkbox"/> <b>VET-PREDC</b> Prednisolone 2.5 mg capsules                                  | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 caps                             |
| <input type="checkbox"/> <b>VET-BUD</b> Budesonide 1 / 2 mg/mL oral suspension (circle)                 | QTY: <input type="checkbox"/> 15 <input type="checkbox"/> 30 mL                               |
| <input type="checkbox"/> <b>VET-BUDC</b> Budesonide 1 mg capsules                                       | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 caps                             |
| <input type="checkbox"/> <b>VET-MMF</b> Mycophenolate mofetil 70 mg capsules                            | QTY: <input type="checkbox"/> 60 <input type="checkbox"/> 180 caps                            |
| GI, LIVER & CUSHING'S (select one)                                                                      | QUANTITY                                                                                      |
| <input type="checkbox"/> <b>VET-CIS</b> Cisapride 5 mg/mL flavored oral suspension                      | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 120 mL  |
| <input type="checkbox"/> <b>VET-CISC</b> Cisapride ____ mg capsules                                     | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 caps                             |
| <input type="checkbox"/> <b>VET-URS</b> Ursodiol 50 / 80 / 100 mg/mL flavored oral suspension (circle)  | QTY: <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 120 mL  |
| <input type="checkbox"/> <b>VET-URSC</b> Ursodiol ____ mg/mL flavored oral suspension (custom strength) | QTY: <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 120 mL  |
| <input type="checkbox"/> <b>VET-TRI</b> Trilostane 5 / 10 / 15 / 20 mg/mL oral suspension (circle)      | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 120 <input type="checkbox"/> 180 mL |
| <input type="checkbox"/> <b>VET-TRIC</b> Trilostane ____ mg capsules (custom strength)                  | QTY: <input type="checkbox"/> 30 <input type="checkbox"/> 60 caps                             |
| CUSTOM – (other formula or strength – call pharmacy to confirm)                                         | QUANTITY                                                                                      |
| <input type="checkbox"/> _____                                                                          | QTY: _____ mL                                                                                 |

### FLAVOR (liquids)

☐ Chicken ☐ Fish ☐ Tuna ☐ Beef ☐ Pharmacy choice if left blank

### REFILLS (circle one)

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

### DIRECTIONS/SIG + SIGNATURE

|                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Give _____ mL or _____ capsule(s) by mouth every _____ hours.                                             |
| <input type="checkbox"/> Apply _____ click(s) ( _____ mg) to the inner ear pinna every _____ hours, alternating ears; wear gloves. |
| <input type="checkbox"/> Other _____                                                                                               |
| X _____<br>Veterinarian's Signature                                                                                                |
| _____<br>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