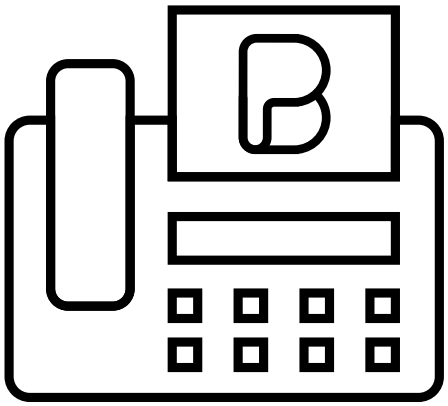
Bayview Pharmacy

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

Bayview Pharmacy

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

Bayview Pharmacy

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 – GABAPENTIN – TOPICAL

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

GABAPENTIN – Topical Gel (anhydrous base) (tube or pump)	QUANTITY
☐ GAB-G2 Gabapentin 2% topical gel	QTY: ☐ 30 ☐ 60 ☐ 90 gm
☐ GAB-G4 Gabapentin 4% topical gel	QTY: ☐ 30 ☐ 60 ☐ 90 gm
☐ GAB-G6 Gabapentin 6% topical gel	QTY: ☐ 30 ☐ 60 ☐ 90 gm
☐ GAB-G10 Gabapentin 10% topical gel	QTY: ☐ 30 ☐ 60 ☐ 90 gm
GABAPENTIN – Topical Cream & Ointment	**QUANTITY**
☐ GAB-C10 Gabapentin 10% topical cream (VersaBase, pump)	QTY: ☐ 30 ☐ 60 gm
☐ GAB-O6 Gabapentin 6% topical ointment	QTY: ☐ 30 ☐ 60 gm
COMBINATION TOPICAL GELS (anhydrous base, pump)	**QUANTITY**
☐ GAB-ADG Amitriptyline 2% / diclofenac 5% / gabapentin 5%	QTY: ☐ 60 ☐ 120 ☐ 240 gm
☐ GAB-GLB Gabapentin 6% / lidocaine 5% / bupivacaine 2%	QTY: ☐ 60 ☐ 120 ☐ 240 gm
☐ GAB-AG Amitriptyline 2% / gabapentin 6%	QTY: ☐ 60 ☐ 120 ☐ 240 gm
TOPICAL SOLUTION – Scalp	**QUANTITY**
☐ GAB-SCP Gabapentin 6% / amitriptyline 2% / lidocaine 1% scalp solution	QTY: ☐ 30 ☐ 60 mL

Vaginal or vulvar gabapentin creams: use the Bayview Vulvodynia order form. Dogs and cats: use the Veterinary order form.

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

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

- ☐ Apply a thin layer to the affected area(s) three times daily as needed.
- ☐ Apply _____ mL (_____ pumps) to the affected area(s) twice daily.
- ☐ Apply to the affected area(s) _____ times daily.
- ☐ Other _____

X _____ _____

Prescriber's Signature Date

4 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

_____ _____

Pharmacy Name Pharmacy Fax Number

The pharmacy name & fax # cannot be pre-printed in order to comply with RI Law 216-RICR-40-15-1 section 1.3A10.

NEW PRESCRIPTION ORDER FORM – GABAPENTIN – 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

GABAPENTIN – Oral Capsule (strengths not manufactured)	QUANTITY
☐ GAB-25 Gabapentin 25 mg capsule	QTY: ☐ 60 ☐ 100 ☐ 180 caps
☐ GAB-50 Gabapentin 50 mg capsule	QTY: ☐ 60 ☐ 100 ☐ 180 caps
GABAPENTIN – Oral Suspension (anhydrous)	**QUANTITY**
☐ GAB-S200 Gabapentin 200 mg/mL oral suspension	QTY: ☐ 30 ☐ 60 ☐ 120 mL
MANUFACTURED STRENGTH – Oral Capsule (reason required below)	**QUANTITY**
☐ GAB-100 Gabapentin 100 mg capsule	QTY: ☐ 90 ☐ 180 caps
☐ GAB-300 Gabapentin 300 mg capsule	QTY: ☐ 90 ☐ 180 caps
MANUFACTURED STRENGTH – Oral Suspension (reason required below)	**QUANTITY**
☐ GAB-S50 Gabapentin 50 mg/mL oral suspension	QTY: ☐ 120 ☐ 540 mL

Commercially available as 100, 300, and 400 mg capsules and a 50 mg/mL solution. Under section 503A, write the change and reason below.

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

REQUIRED – CHANGE FROM THE COMMERCIAL PRODUCT AND REASON

For a manufactured strength: what must differ, and why this patient needs it:

_____

Example: "No dye, patient allergy."

Change: ☐ Leave out an ingredient _____ ☐ Other _____

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Take 1 capsule by mouth _____ times daily.

☐ Take _____ mL by mouth _____ times daily.

☐ Increase by _____ every _____ days as directed, up to _____ .

☐ Other _____

X _____ _____

Prescriber's Signature Date

4 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

_____ _____

Pharmacy Name Pharmacy Fax Number

The pharmacy name & fax # cannot be pre-printed in order to comply with RI Law 216-RICR-40-15-1 section 1.3A10.