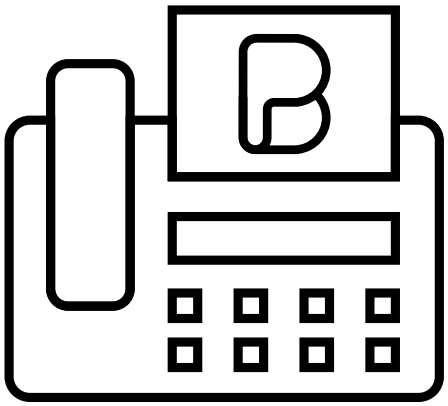
Bayview Pharmacy

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

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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

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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.

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Fax: 401-284-4506
Alternate Fax: 401-210-2757
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NEW PRESCRIPTION ORDER FORM – ORAL LICHEN PLANUS – RINSES

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

STEROID MOUTH RINSE (swish and spit)	QUANTITY
☐ CLB-R025 Clobetasol propionate 0.025% oral rinse, mucoadhesive base	QTY: ☐ 60 ☐ 120 ☐ 240 mL
☐ CLB-R05 Clobetasol propionate 0.05% oral rinse	QTY: ☐ 60 ☐ 120 ☐ 240 mL

STEROID MOUTH RINSE (swish and spit)	QUANTITY
☐ FLU-R05 Fluocinonide 0.05% oral rinse	QTY: ☐ 240 ☐ 300 ☐ 600 mL
☐ TRI-R1 Triamcinolone acetonide 0.1% oral rinse	QTY: ☐ 240 ☐ 300 ☐ 600 mL
☐ TRI-R2 Triamcinolone acetonide 0.2% oral rinse	QTY: ☐ 240 ☐ 300 ☐ 600 mL
☐ TRI-R4 Triamcinolone acetonide 0.4% oral rinse, preservative-free	QTY: ☐ 240 ☐ 300 ☐ 600 mL
☐ BET-R025 Betamethasone 0.025% oral rinse	QTY: ☐ 240 ☐ 300 ☐ 600 mL

TACROLIMUS MOUTH RINSE (swish and spit)	QUANTITY
☐ TAC-R03 Tacrolimus 0.03% oral rinse, anhydrous suspension	QTY: ☐ 480 ☐ 960 ☐ 1440 mL
☐ TAC-R1 Tacrolimus 0.1% oral rinse, anhydrous suspension	QTY: ☐ 480 ☐ 960 ☐ 1440 mL

Tacrolimus is usually second-line in oral lichen planus. The skin ointment is labeled not for oral use and carries the topical calcineurin inhibitor boxed warning.

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

☐ Swish _____ mL for _____ minutes and spit _____ times daily for _____ days. Do not swallow. Nothing by mouth for 30 minutes after.

☐ 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 – ORAL LICHEN PLANUS – PASTES

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

ADHESIVE PASTE / GEL	QUANTITY
☐ CLB-D05 Clobetasol propionate 0.05% dental paste	QTY: ☐ 15 ☐ 30 ☐ 60 g
☐ CLB-DL Lidocaine 1% / clobetasol propionate 0.05% oral gel, mucoadhesive base	QTY: ☐ 15 ☐ 30 ☐ 60 g
☐ FLU-P05 Fluocinonide 0.05% oral adhesive paste	QTY: ☐ 15 ☐ 30 ☐ 60 g

TRIAMCINOLONE DENTAL PASTE	QUANTITY
☐ TRI-P1 Triamcinolone acetonide 0.1% oral adhesive paste	QTY: ☐ 5 ☐ 15 g

Manufactured triamcinolone acetonide 0.1% dental paste is FDA-approved and dispensed when it fits. A compounded 0.1% paste needs the patient-specific change and reason written on the prescription (503A).

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

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Dry the area and press a small dab onto the lesion(s) _____ times daily, including at bedtime. Do not rub in. Nothing by mouth for 30 minutes after.

☐ Course: _____ weeks, then review. Counsel on oral candidiasis; add an antifungal if it develops.

☐ 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.