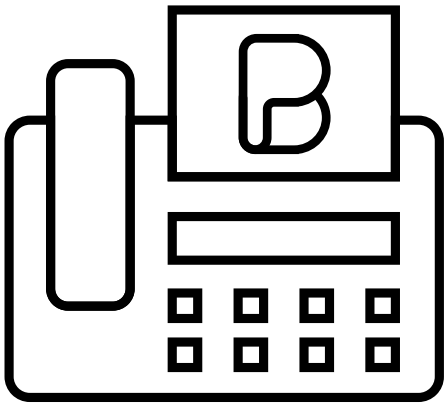
Bayview Pharmacy

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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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

THE FASTEST WAY — PRESCRIBE WITH BAYVIEW CODES

Every validated formulation has a short **Bayview code** (like **TP500**) — the same codes printed on the order form and the validated formulations sheet. Instead of typing out every ingredient, put the code first in your compound / free-text entry and we match it to the exact validated formulation instantly:

> Bayview TP500 — Alprostadil 500 mcg/ml + Papaverine 7.5 mg/ml + Phentolamine 1 mg/ml, 1 x 0.25 ml prefilled applicator

Include the quantity, directions/SIG, and refills as usual. If your EHR only accepts a plain formulation name, type it 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 – ED URETHRAL GELS

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

TRIPLE-P GEL – Alprostadil + Papaverine + Phentolamine	QUANTITY (0.25 ml Applicators)
☐ TP250 Alprostadil 250 mcg/ml + Papaverine 7.5 mg/ml + Phentolamine 1 mg/ml	QTY: ____ Applicator(s)
☐ TP500 Alprostadil 500 mcg/ml + Papaverine 7.5 mg/ml + Phentolamine 1 mg/ml	QTY: ____ Applicator(s)
☐ TP750 Alprostadil 750 mcg/ml + Papaverine 7.5 mg/ml + Phentolamine 1 mg/ml	QTY: ____ Applicator(s)
☐ TP1000 Alprostadil 1000 mcg/ml + Papaverine 7.5 mg/ml + Phentolamine 1 mg/ml	QTY: ____ Applicator(s)
BIMIX GEL – Papaverine + Phentolamine	**QUANTITY (0.25 ml Applicators)**
☐ BG1 Papaverine 7.5 mg/ml + Phentolamine 1 mg/ml	QTY: ____ Applicator(s)
☐ BG2 Papaverine 7.5 mg/ml + Phentolamine 2 mg/ml	QTY: ____ Applicator(s)
SAMPLE KITS – Triple-P Gel, 0.25 ml applicators	**QUANTITY**
☐ KIT1 Sample Kit 1: (2) TP250 + (2) TP500 (4 applicators)	QTY: ____ Kit(s)
☐ KIT2 Sample Kit 2: (2) TP750 + (2) TP1000 (4 applicators)	QTY: ____ Kit(s)
☐ KIT-C Custom kit: ____ TP250 ____ TP500 ____ TP750 ____ TP1000	Applicators each (minimum 2 per strength)
CUSTOM – (call pharmacy to confirm)	**QUANTITY (0.25 ml Applicators)**
☐ _____	QTY: ____ Applicator(s)

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Insert the contents of one 0.25 ml applicator into the urethral opening 10–15 minutes before sexual activity, as directed.

☐ If response is inadequate, prescriber may step up to the next validated strength. Use no more than _____ *(usually 3)* times per week, and never more than one dose in any 24 hours.

☐ 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