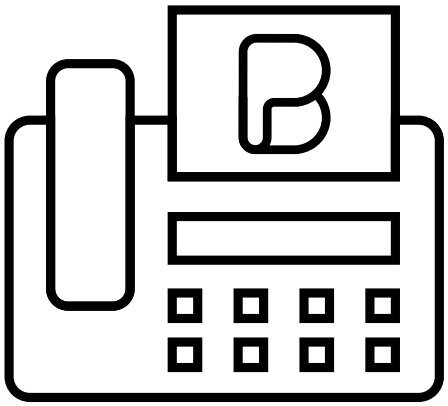
Bayview Pharmacy

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 to your healthcare provider.** They must complete and sign it.
- Do **not** fill out the prescriber sections yourself.

What Happens Next

1. **We reach out** to go over the prescription.
2. **The patient pays by text** and picks shipping or pickup.
3. **We make it,** usually within 1 to 2 business days.
4. **We ship it,** or the patient picks it up.

   If we have to order an ingredient, allow extra time.

3844 Post Road, Warwick RI 02886
Phone: 401-284-4505
Fax: 401-284-4506
Alternate Fax: 401-210-2757
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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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NEW PRESCRIPTION ORDER FORM – CLINDAMYCIN – ORAL, RECTAL & VAGINAL

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

CLINDAMYCIN – Oral Capsule (gluten free)	QUANTITY
☐ CLI-C150 Clindamycin 150 mg capsule (gluten free)	QTY: ☐ 30 ☐ 60 ☐ 90 caps
☐ CLI-C40 Clindamycin HCl 40.72 mg capsule	QTY: ☐ 30 ☐ 60 ☐ 90 caps

Boxed warning (oral): C. difficile-associated diarrhea. 150 mg matches a manufactured capsule; note the clinical reason a compounded capsule is needed.

CLINDAMYCIN – Suppository	QUANTITY
☐ CLI-R150 Clindamycin 150 mg rectal suppository	QTY: ☐ 3 ☐ 7 supp
☐ CLI-V150 Clindamycin 150 mg vaginal suppository	QTY: ☐ 3 ☐ 7 supp

CLINDAMYCIN – Vaginal Gel	QUANTITY
☐ CLI-VG Clindamycin phosphate 2.38% vaginal gel	QTY: ☐ 40 ☐ 60 gm

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

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 for _____ days.

☐ Insert 1 suppository rectally / vaginally at bedtime for _____ days.

☐ Insert 1 applicatorful vaginally at bedtime for _____ days.

☐ 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 – CLINDAMYCIN – SKIN, SCALP & NASAL

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

CLINDAMYCIN – Topical Gel	QUANTITY
☐ CLI-TG Clindamycin phosphate 1.19% topical gel	QTY: ☐ 30 ☐ 60 gm
CLINDAMYCIN – Shampoo	**QUANTITY**
☐ CLI-SH1 Clindamycin 1% shampoo	QTY: ☐ 120 ☐ 240 mL
CLINDAMYCIN – Nasal	**QUANTITY**
☐ CLI-NS1 Clindamycin 1% nasal spray	QTY: ☐ 15 ☐ 30 ☐ 240 mL
☐ CLI-NI06 Clindamycin 0.6 mg/mL nasal irrigation liquid	QTY: ☐ 15 ☐ 30 ☐ 240 mL
CUSTOM – (other formula or strength – call pharmacy to confirm)	**QUANTITY**
☐ _____	QTY: _____

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 _____ times daily.
- ☐ Lather into wet scalp, leave on _____ minutes, then rinse. Use _____ times weekly.
- ☐ Spray _____ sprays in each nostril _____ times daily.
- ☐ Irrigate each nostril with _____ mL _____ 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.