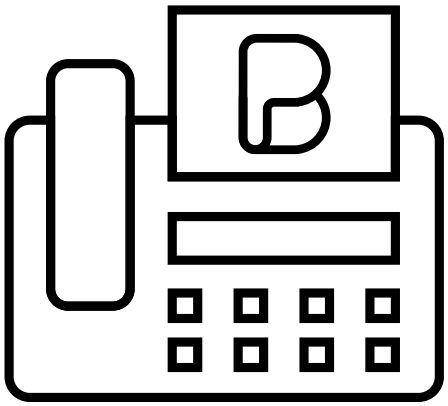
Bayview Pharmacy

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 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
www.bayviewrx.com

# Bayview Pharmacy

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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 – TOPICAL SODIUM THIOSULFATE

## 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

| SODIUM THIOSULFATE – Cream | QUANTITY |
|---|---|
| ☐ STS-20P Sodium thiosulfate 20% cream, metered pump (0.5 mL/actuation) | QTY: ☐ 50–60 mL |
| ☐ STS-25 Sodium thiosulfate 25% cream | QTY: ☐ 60 mL |
| ☐ STS-25F Sodium thiosulfate 25% cream, fragrance free | QTY: ☐ 60 mL |
| ☐ STS-25Z Sodium thiosulfate 25% in zinc oxide cream (jar) | QTY: ☐ 60 gm |
| **SODIUM THIOSULFATE – Gel & Solution** | **QUANTITY** |
| ☐ STS-25ZG Sodium thiosulfate 25% / zinc oxide 20% gel (jar) | QTY: ☐ 60 gm |
| ☐ STS-25S Sodium thiosulfate 25% solution | QTY: ☐ 30 ☐ 175 mL |

**Specify a fragrance-free base if odour is a concern – the sulfur smell is the commonest reason patients stop. ICD-10: L94.2.**

| CUSTOM – (other strength, base or size – 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) twice daily.

☐ Apply a thin layer to the affected area(s) _____ times daily, with a dressing as directed.

☐ 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