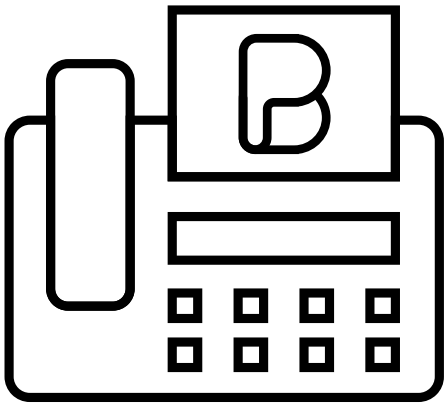
Bayview Pharmacy

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 – SILDENAFIL

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

SILDENAFIL – Tablets (swallowed 30–60 min before activity)					QUANTITY
☐ SIL-T20 Sildenafil 20 mg tablet	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
☐ SIL-T25 Sildenafil 25 mg tablet	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
☐ SIL-T50 Sildenafil 50 mg tablet	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
☐ SIL-T100 Sildenafil 100 mg tablet	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
SILDENAFIL – Troches (dissolved between cheek and gum)					**QUANTITY**
☐ SIL-TR25 Sildenafil 25 mg troche	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
☐ SIL-TR50 Sildenafil 50 mg troche	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
☐ SIL-TR100 Sildenafil 100 mg troche	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
SILDENAFIL – Rapid Dissolve Tablets (under the tongue, 1–2 min)					**QUANTITY**
☐ SIL-R50 Sildenafil 50 mg RDT	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
☐ SIL-R100 Sildenafil 100 mg RDT	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
CUSTOM – (other strength or dose form – call pharmacy to confirm)					**QUANTITY**
☐ _____	QTY: _____ units				

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Take or dissolve 1 dose _____ minutes before sexual activity, as needed. Max 1 dose in 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

NEW PRESCRIPTION ORDER FORM – TADALAFIL

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

TADALAFIL – Tablets (swallowed; on-demand or daily)					QUANTITY
☐ TAD-T5 Tadalafil 5 mg tablet	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
☐ TAD-T10 Tadalafil 10 mg tablet	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
☐ TAD-T20 Tadalafil 20 mg tablet	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
TADALAFIL – Troches (dissolved between cheek and gum)					**QUANTITY**
☐ TAD-TR5 Tadalafil 5 mg troche	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
☐ TAD-TR10 Tadalafil 10 mg troche	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
☐ TAD-TR20 Tadalafil 20 mg troche	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
TADALAFIL – Rapid Dissolve Tablets (under the tongue, 1–2 min)					**QUANTITY**
☐ TAD-R5 Tadalafil 5 mg RDT	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
☐ TAD-R10 Tadalafil 10 mg RDT	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
☐ TAD-R20 Tadalafil 20 mg RDT	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
CUSTOM – (other strength or dose form – call pharmacy to confirm)					**QUANTITY**
☐ _____	QTY: _____ units				

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Take or dissolve 1 dose _____ minutes before sexual activity, as needed. Max 1 dose in 24 hours.

☐ Take 1 dose by mouth once daily, at the same time each day.

☐ 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

NEW PRESCRIPTION ORDER FORM – VARDENAFIL

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

VARDENAFIL – Troches (dissolved between cheek and gum)					QUANTITY
☐ VAR-TR5 Vardenafil 5 mg troche	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
☐ VAR-TR10 Vardenafil 10 mg troche	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
☐ VAR-TR20 Vardenafil 20 mg troche	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
VARDENAFIL – Rapid Dissolve Tablets (under the tongue, 1–2 min)					**QUANTITY**
☐ VAR-R20 Vardenafil 20 mg RDT	QTY: ☐ 10	☐ 30	☐ 60	☐ 90 units	
CUSTOM – (other strength or dose form – call pharmacy to confirm)					**QUANTITY**
☐ _____	QTY: _____ units				

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Take or dissolve 1 dose _____ minutes before sexual activity, as needed. Max 1 dose in 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 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