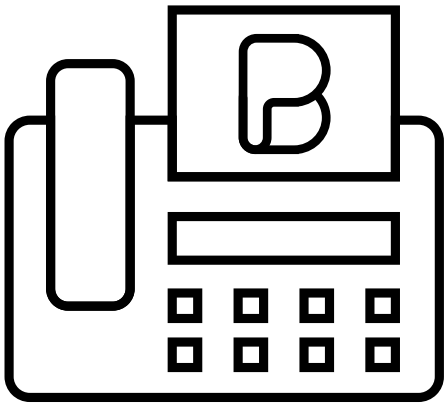
Bayview Pharmacy

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

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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.

3844 Post Road, Warwick RI 02886
Phone: 401-284-4505
Fax: 401-284-4506
Alternate Fax: 401-210-2757
www.bayviewrx.com

NEW PRESCRIPTION ORDER FORM – HAIR LOSS (MEN) (1 OF 2)

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

MEN – Topical Scalp Solution or Foam (select one formula)	QUANTITY
☐ HLM-MF5 Minoxidil 5% / finasteride 0.1% solution	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLM-MT2 Minoxidil 2% / tretinoin 0.025% solution (mild)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLM-MF3 Minoxidil 3% / finasteride 0.25% solution (mild)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLM-MDT Minoxidil 5% / dutasteride 0.05% / tretinoin 0.025% solution (moderate)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLM-MAD Minoxidil 5% / azelaic acid 1.5% / dutasteride 0.05% foam (moderate)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLM-MFTF Minoxidil 10% / finasteride 0.1% / tretinoin 0.025% / fluocinolone 0.025% solution	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLM-MBF Minoxidil 10% / biotin 0.2% / finasteride 0.1% solution (severe)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLM-M15 Minoxidil 15% foam (severe)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLM-MTC Minoxidil 5% / tacrolimus 0.3% / clobetasol 0.05% foam (inflammatory / alopecia areata)	QTY: ☐ 30 ☐ 60 ☐ 120 mL

MEN – Oral Capsules (select one formula)	QUANTITY
☐ HLM-C25 Minoxidil 0.25 mg / finasteride 1 mg capsule (mild)	QTY: ☐ 30 ☐ 90 caps
☐ HLM-C5 Minoxidil 0.5 mg / finasteride 1 mg capsule (moderate)	QTY: ☐ 30 ☐ 90 caps
☐ HLM-C1 Minoxidil 1 mg / finasteride 1 mg capsule (severe)	QTY: ☐ 30 ☐ 90 caps
☐ HLM-C51 Minoxidil 5 mg / finasteride 1 mg capsule	QTY: ☐ 30 ☐ 90 caps

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

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

- ☐ Apply 1 mL to the dry scalp once daily at bedtime.
- ☐ Apply 1 mL (2 pumps) to the scalp twice daily.
- ☐ Take 1 capsule by mouth once 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

NEW PRESCRIPTION ORDER FORM – HAIR LOSS (MEN) (2 OF 2)

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

SHAMPOO (select one formula)	QUANTITY
☐ HL-KET Ketoconazole 2% shampoo	QTY: ☐ 120 ☐ 240 mL
☐ HL-ZPC Zinc pyrithione 0.25% / clobetasol 0.05% scalp spray	QTY: ☐ 120 ☐ 240 mL

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

- ☐ Apply 1 mL to the dry scalp once daily at bedtime.
- ☐ Apply 1 mL (2 pumps) to the scalp twice daily.
- ☐ Take 1 capsule by mouth once 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

NEW PRESCRIPTION ORDER FORM – HAIR LOSS (WOMEN)

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

WOMEN – Topical Scalp Solution or Foam (select one formula)	QUANTITY
☐ HLW-MT2 Minoxidil 2% / tretinoin 0.025% solution (mild)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-MT1 Minoxidil 1% / tretinoin 0.025% gel (mild, sensitive)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-MFT Minoxidil 5% / finasteride 0.1% / tretinoin 0.025% solution	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-MFTS Minoxidil 6% / finasteride 0.1% / tretinoin 0.0125% / spironolactone 0.25% solution	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-MTS Minoxidil 6% / tretinoin 0.01% / spironolactone 0.5% solution (moderate)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-MPT Minoxidil 5% / progesterone 0.25% / tretinoin 0.025% solution	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-MPS Minoxidil 5% / progesterone 0.25% / spironolactone 3% foam	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-ME Minoxidil 5% / estradiol 0.025% gel	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-MT8 Minoxidil 8% / tretinoin 0.01% solution (severe)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ HLW-MF10 Minoxidil 10% / finasteride 0.1% solution (severe)	QTY: ☐ 30 ☐ 60 ☐ 120 mL

WOMEN – Oral (select one formula)	QUANTITY
☐ HLW-MS25 Minoxidil 0.25 mg / spironolactone 25 mg capsule	QTY: ☐ 30 ☐ 90 caps/mL
☐ HLW-MS5 Minoxidil 0.5 mg / spironolactone 25 mg capsule	QTY: ☐ 30 ☐ 90 caps/mL
☐ HLW-M125 Minoxidil 0.125 mg capsule (low-dose oral minoxidil)	QTY: ☐ 30 ☐ 90 caps/mL
☐ HLW-MSOL Minoxidil 2.5 mg/mL oral solution	QTY: ☐ 30 ☐ 90 caps/mL

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

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Apply 1 mL to the dry scalp once daily at bedtime.

☐ Take 1 capsule by mouth once daily.

☐ Take _____ mL by mouth once 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