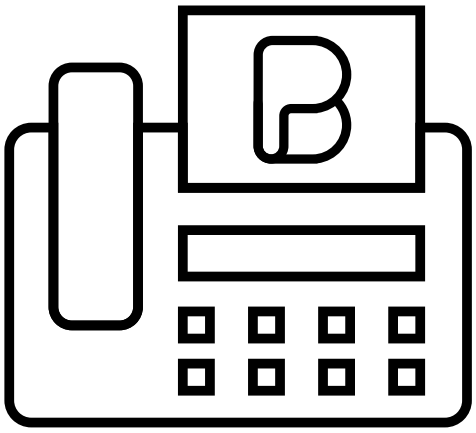
Bayview Pharmacy

Your modern compounding pharmacy.™

FAX COVER SHEET



Please fax your order to:

401–284–4506

A new name is coming. Bayview Pharmacy is becoming Formwell™.
Same pharmacists, same lab. Keep sending prescriptions the way you do now. Our fax, phone, NCPDP and e-prescribing listing stay the same.

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.

A new name is coming. Bayview Pharmacy is becoming Formwell™. Same pharmacists, same lab, same phone and fax. Prescriptions and refills carry over automatically.

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.

NEW PRESCRIPTION ORDER FORM – VET 1/4: CARDIOVASCULAR

1 Patient (Pet) and Owner Information

Pet Name	Species ○ Dog ○ Cat ○ Other	Breed	Weight ○ lb ○ kg
Owner Last Name	Owner First Name	Pet Date of Birth or Age	
Address			Apt. #
City	State	ZIP	Owner Phone
Owner Email	Allergies / other medications		

2 Veterinarian Information

Veterinarian's Name	Clinic or Hospital	
Phone Number	Fax Number	
Street Address		
City	State	ZIP
State License #	DEA (controlled only)	NPI (if any)

3 Medication Selection

HEART DISEASE & BLOOD PRESSURE (select one)	QUANTITY
☐ VET-PIM Pimobendan 1.25 / 1.5 / 2 / 2.5 / 3 / 4 / 10 mg/mL flavored oral suspension (circle)	QTY: ☐ 30 ☐ 60 ☐ 90 mL
☐ VET-PIMC Pimobendan 2.5 / 10 / 15 mg capsules (circle)	QTY: ☐ 60 ☐ 100 caps
☐ VET-PIMS Pimobendan 2 mg/mL + sildenafil 10 mg/mL oral suspension	QTY: ☐ 30 ☐ 60 ☐ 90 mL
☐ VET-ATEN Atenolol 6.25 mg per 0.1 mL transdermal ear gel, TopiClick	QTY: ☐ 3 ☐ 6 ☐ 9 mL
☐ VET-AML Amlodipine 2.5 mg/mL flavored oral suspension	QTY: ☐ 15 ☐ 30 mL
☐ VET-BEN Benazepril 4 / 5 mg/mL oral suspension (circle)	QTY: ☐ 30 ☐ 60 mL
☐ VET-BENC Benazepril 2.5 mg capsules	QTY: ☐ 30 ☐ 60 caps
☐ VET-ENA Enalapril 3 / 10 mg/mL oral suspension (circle)	QTY: ☐ 30 ☐ 60 mL
☐ VET-CLO Clopidogrel 75 mg/mL oral suspension	QTY: ☐ 15 ☐ 30 mL
☐ VET-FUR Furosemide 12 / 25 mg/mL oral suspension (circle)	QTY: ☐ 30 ☐ 60 mL
☐ VET-SPI Spironolactone 3 / 10 mg/mL oral suspension (circle)	QTY: ☐ 30 ☐ 60 mL
☐ VET-BCF Benazepril 2.5 / clopidogrel 37.5 / furosemide 10 mg/mL oral suspension	QTY: ☐ 30 ☐ 60 mL

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

FLAVOR (liquids)

☐ Chicken ☐ Fish ☐ Tuna ☐ Beef ☐ Pharmacy choice if left blank

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Give _____ mL or _____ capsule(s) by mouth every _____ hours.

☐ Apply _____ click(s) (_____ mg) to the inner ear pinna every _____ hours, alternating ears; wear gloves.

☐ Other _____

X _____ _____

Veterinarian'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 – VET 2/4: THYROID & BEHAVIOR

1 Patient (Pet) and Owner Information

Pet Name	Species ○ Dog ○ Cat ○ Other	Breed	Weight ○ lb ○ kg
Owner Last Name	Owner First Name	Pet Date of Birth or Age	
Address			Apt. #
City	State	ZIP	Owner Phone
Owner Email	Allergies / other medications		

2 Veterinarian Information

Veterinarian's Name	Clinic or Hospital	
Phone Number	Fax Number	
Street Address		
City	State	ZIP
State License #	DEA (controlled only)	NPI (if any)

3 Medication Selection

HYPERTHYROIDISM (CATS) (select one)	QUANTITY
☐ VET-MET Methimazole 2.5 / 5 / 10 mg/mL flavored oral suspension (circle)	QTY: ☐ 30 ☐ 60 ☐ 90 mL
☐ VET-METT Methimazole 1.25 / 2.5 / 5 mg per 0.1 mL transdermal ear gel, TopiClick (circle)	QTY: ☐ 3 ☐ 6 ☐ 9 mL
☐ VET-METTC Methimazole ____ mg per 0.1 mL transdermal ear gel (custom strength)	QTY: ☐ 3 ☐ 6 ☐ 9 mL

ANXIETY & BEHAVIOR (select one)	QUANTITY
☐ VET-FLX Fluoxetine 2.5 / 3 / 4 / 5 mg capsules (circle)	QTY: ☐ 30 ☐ 60 caps
☐ VET-FLXL Fluoxetine 12 mg/mL flavored oral suspension	QTY: ☐ 15 ☐ 30 mL
☐ VET-TRAZ Trazodone 50 / 100 mg/mL flavored oral suspension (circle)	QTY: ☐ 3 ☐ 15 ☐ 30 mL
☐ VET-TRAZT Trazodone 100 mg/g transdermal ear gel, TopiClick	QTY: ☐ 6 ☐ 15 g
☐ VET-AMIT Amitriptyline 5 / 10 mg per 0.1 mL transdermal ear gel, TopiClick (circle)	QTY: ☐ 3 ☐ 6 ☐ 9 mL
☐ VET-GAB Gabapentin 100 / 300 mg/mL flavored oral suspension (circle)	QTY: ☐ 10 ☐ 30 ☐ 60 mL
☐ VET-GABC Gabapentin 45 mg capsules	QTY: ☐ 21 ☐ 30 ☐ 60 caps
☐ VET-GABT Gabapentin 40 mg per 0.1 mL transdermal ear gel, TopiClick	QTY: ☐ 3 ☐ 6 ☐ 9 mL

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

FLAVOR (liquids)

☐ Chicken ☐ Fish ☐ Tuna ☐ Beef ☐ Pharmacy choice if left blank

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Give _____ mL or _____ capsule(s) by mouth every _____ hours.

☐ Give _____ mL by mouth _____ minutes before the stressful event, as needed.

☐ Apply _____ click(s) (_____ mg) to the inner ear pinna every _____ hours, alternating ears; wear gloves.

☐ Other _____

X _____ _____

Veterinarian'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 – VET 3/4: SEIZURES & URINARY

1 Patient (Pet) and Owner Information

Pet Name	Species ○Dog ○Cat ○Other	Breed	Weight ○lb ○kg
Owner Last Name	Owner First Name	Pet Date of Birth or Age	
Address			Apt. #
City	State	ZIP	Owner Phone
Owner Email	Allergies / other medications		

2 Veterinarian Information

Veterinarian's Name	Clinic or Hospital	
Phone Number	Fax Number	
Street Address		
City	State	ZIP
State License #	DEA (controlled only)	NPI (if any)

3 Medication Selection

SEIZURES & EPILEPSY (select one)	QUANTITY
☐ VET-LEV Levetiracetam 100 mg/mL oral suspension	QTY: ☐ 60 ☐ 160 mL
☐ VET-ZON Zonisamide 20 / 50 mg/mL oral suspension (circle)	QTY: ☐ 30 ☐ 60 mL
☐ VET-KBR Potassium bromide 250 mg/mL oral solution (dogs only)	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ VET-KBRC Potassium bromide 500 / 750 mg capsules (dogs only) (circle)	QTY: ☐ 90 ☐ 180 caps
Gabapentin as a seizure add-on: order it from the Anxiety & Behavior section above (VET-GAB).	

URINARY INCONTINENCE & STONES (select one)	QUANTITY
☐ VET-PPA Phenylpropanolamine HCl 10 / 25 / 50 mg/mL flavored oral suspension (circle)	QTY: ☐ 30 ☐ 60 mL
☐ VET-KCIT Potassium citrate 500 mg/mL oral solution	QTY: ☐ 30 ☐ 120 ☐ 420 mL
☐ VET-PRAZ Prazosin 1 mg/mL oral suspension	QTY: ☐ 30 ☐ 60 mL

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

FLAVOR (liquids)

☐ Chicken ☐ Fish ☐ Tuna ☐ Beef ☐ Pharmacy choice if left blank

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Give _____ mL or _____ capsule(s) by mouth every _____ hours.

☐ Apply _____ click(s) (_____ mg) to the inner ear pinna every _____ hours, alternating ears; wear gloves.

☐ Other _____

X _____ _____

Veterinarian's Signature Date

4 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

_____ _____

Pharmacy Name

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Pharmacy Fax Number

NEW PRESCRIPTION ORDER FORM – VET 4/4: INFLAMMATION & GI

1 Patient (Pet) and Owner Information

Pet Name	Species ○Dog ○Cat ○Other	Breed	Weight ○lb ○kg
Owner Last Name	Owner First Name	Pet Date of Birth or Age	
Address			Apt. #
City	State	ZIP	Owner Phone
Owner Email	Allergies / other medications		

2 Veterinarian Information

Veterinarian's Name	Clinic or Hospital	
Phone Number	Fax Number	
Street Address		
City	State	ZIP
State License #	DEA (controlled only)	NPI (if any)

3 Medication Selection

ALLERGIES, INFLAMMATION & IBD (select one)	QUANTITY
☐ VET-PRED Prednisolone 5 / 10 mg/mL flavored oral suspension (circle)	QTY: ☐ 10 ☐ 15 ☐ 30 mL
☐ VET-PREDT Prednisolone 7 mg per 0.1 mL transdermal ear gel, TopiClick	QTY: ☐ 3 ☐ 6 ☐ 9 mL
☐ VET-PREDC Prednisolone 2.5 mg capsules	QTY: ☐ 30 ☐ 60 caps
☐ VET-BUD Budesonide 1 / 2 mg/mL oral suspension (circle)	QTY: ☐ 15 ☐ 30 mL
☐ VET-BUDC Budesonide 1 mg capsules	QTY: ☐ 30 ☐ 60 caps
☐ VET-MMF Mycophenolate mofetil 70 mg capsules	QTY: ☐ 60 ☐ 180 caps

GI, LIVER & CUSHING'S (select one)	QUANTITY
☐ VET-CIS Cisapride 5 mg/mL flavored oral suspension	QTY: ☐ 30 ☐ 60 ☐ 120 mL
☐ VET-CISC Cisapride ____ mg capsules	QTY: ☐ 30 ☐ 60 caps
☐ VET-URS Ursodiol 50 / 80 / 100 mg/mL flavored oral suspension (circle)	QTY: ☐ 60 ☐ 90 ☐ 120 mL
☐ VET-URSC Ursodiol ____ mg/mL flavored oral suspension (custom strength)	QTY: ☐ 60 ☐ 90 ☐ 120 mL
☐ VET-TRI Trilostane 5 / 10 / 15 / 20 mg/mL oral suspension (circle)	QTY: ☐ 30 ☐ 120 ☐ 180 mL
☐ VET-TRIC Trilostane ____ mg capsules (custom strength)	QTY: ☐ 30 ☐ 60 caps

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

FLAVOR (liquids)

☐ Chicken ☐ Fish ☐ Tuna ☐ Beef ☐ Pharmacy choice if left blank

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Give _____ mL or _____ capsule(s) by mouth every _____ hours.

☐ Apply _____ click(s) (_____ mg) to the inner ear pinna every _____ hours, alternating ears; wear gloves.

☐ Other _____

X _____ _____

Veterinarian's Signature Date

4 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

_____ _____

Pharmacy Name Pharmacy Fax Number

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