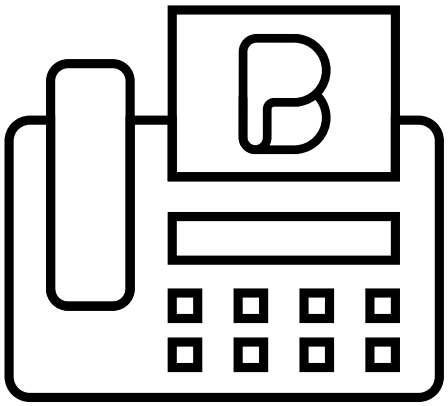
Bayview Pharmacy

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

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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.

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NEW PRESCRIPTION ORDER FORM – MELASMA & DARK SPOTS

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

MELASMA & HYPERPIGMENTATION – Topical Gel or Cream (select one formula)	QUANTITY
☐ MEL-HKT Hydroquinone 8% / kojic acid 6% / tranexamic acid 3% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ MEL-HHKNT Hydroquinone 12% / hydrocortisone 1% / kojic acid 6% / niacinamide 2% / tretinoin 0.05% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ MEL-HHKN Hydroquinone 12% / hydrocortisone 1% / kojic acid 6% / niacinamide 2% gel (tretinoin-free)	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ MEL-HANK Hydroquinone 4% / azelaic acid 10% / niacinamide 4% / kojic acid 2% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ MEL-HQ6 Hydroquinone 6% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ MEL-HQ4T Hydroquinone 4% / tretinoin 0.025% / hydrocortisone 1% cream (modified Kligman)	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ MEL-TXA10 Tranexamic acid 10% cream	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ MEL-ATS Azelaic acid 10% / tretinoin 0.0125% / salicylic acid 5% cream	QTY: ☐ 30 ☐ 45 ☐ 60 gm

Hydroquinone courses are usually limited to 8–12 weeks, then a hydroquinone-free maintenance formula.

CUSTOM – (other formula or strength – 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 pea-sized amount to the affected area(s) nightly.
- ☐ Apply to dark spots only, once daily; use sunscreen every morning.
- ☐ Start 2–3 nights per week and increase as tolerated.
- ☐ 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 – WRINKLES & FINE LINES

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

ANTI-AGING – Tretinoin / Niacinamide / Sodium Hyaluronate Gel (select one formula)	QUANTITY
☐ WRK-T01 Tretinoin 0.01% / niacinamide 2% / sodium hyaluronate 0.05% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ WRK-T025 Tretinoin 0.025% / niacinamide 2% / sodium hyaluronate 0.05% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ WRK-T05 Tretinoin 0.05% / niacinamide 2% / sodium hyaluronate 0.05% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
☐ WRK-T1 Tretinoin 0.1% / niacinamide 2% / sodium hyaluronate 0.05% gel	QTY: ☐ 30 ☐ 45 ☐ 60 gm
SCARS & STRETCH MARKS – Topical Gel (select one formula)	**QUANTITY**
☐ SCR-TRE Tretinoin 0.1% gel	QTY: ☐ 30 ☐ 60 gm
☐ SCR-TOP Topiramate 2.5% / aloe vera 0.5% gel	QTY: ☐ 30 ☐ 60 gm
☐ SCR-SIL Tretinoin 0.05% / sodium hyaluronate 0.5% silicone scar gel	QTY: ☐ 30 ☐ 60 gm
CUSTOM – (other formula or strength – 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 pea-sized amount to the entire face nightly.
- ☐ Start 2–3 nights per week and increase to nightly as tolerated.
- ☐ Apply a thin layer to the scar/stretch marks twice 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