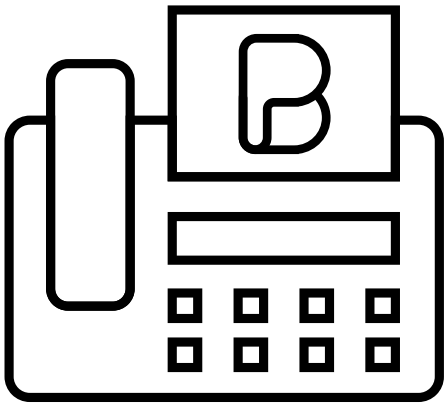
Bayview Pharmacy

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.

3844 Post Road, Warwick RI 02886
Phone: 401-284-4505
Fax: 401-284-4506
Alternate Fax: 401-210-2757
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NEW PRESCRIPTION ORDER FORM – WARTS & MOLLUSCUM (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

PROVIDER-APPLIED (in office only) – Topical Liquid (select one)	QUANTITY
☐ WRT-CPS30 Cantharidin 1% / podophyllin 5% / salicylic acid 30% liquid	QTY: ☐ 5 ☐ 10 mL
☐ WRT-CPS25 Cantharidin 1% / podophyllin 5% / salicylic acid 25% liquid	QTY: ☐ 5 ☐ 10 mL
☐ WRT-CS30 Cantharidin 1% / salicylic acid 30% liquid	QTY: ☐ 5 ☐ 10 mL
☐ WRT-CAN1 Cantharidin 1% liquid (molluscum)	QTY: ☐ 5 ☐ 10 mL
☐ WRT-SPT Salicylic acid 10% / podophyllin 10% / trichloroacetic acid 10% solution	QTY: ☐ 5 ☐ 10 mL

PATIENT-APPLIED – Topical (select one formula)	QUANTITY
☐ WRT-SQ1 Squaric acid dibutyl ester 0.1% solution	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
☐ WRT-SQ2 Squaric acid dibutyl ester 0.2% solution	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
☐ WRT-SA40 Salicylic acid 40% ointment	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
☐ WRT-SA17 Salicylic acid 16.7% in flexible collodion	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
☐ WRT-IMQ5 Imiquimod 5% cream	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
☐ WRT-CDI Cimetidine 10% / deoxy-D-glucose 0.2% / ibuprofen 2% cream	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL
☐ WRT-CIM Cimetidine 60 mg/mL oral suspension	QTY: ☐ 15 ☐ 30 ☐ 60 gm/mL

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

OFFICE USE – provider-applied or office-stocked items

Charge to: ☐ Patient ☐ Office **Ship to:** ☐ Patient ☐ Office ☐ Patient pick-up

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Provider applies to lesion(s) in office; wash off after _____ hours.

☐ Apply to wart(s) twice daily; cover as directed.

☐ Apply 3 nights per week at bedtime; wash off in the morning.

☐ 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 – WARTS & MOLLUSCUM (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

GENITAL WARTS – Vaginal / Rectal (select one formula)	QUANTITY
☐ GWT-IMQ05 Imiquimod 0.5% vaginal gel	QTY: ☐ 30 ☐ 14 gm/count
☐ GWT-IMQS Imiquimod 6 mg suppository	QTY: ☐ 30 ☐ 14 gm/count
☐ GWT-DAI Deoxy-D-glucose 0.2% / acyclovir 5% / imiquimod 2.5% / tea tree oil 2.5% vaginal gel	QTY: ☐ 30 ☐ 14 gm/count

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

OFFICE USE – provider-applied or office-stocked items

Charge to: ☐ Patient ☐ Office **Ship to:** ☐ Patient ☐ Office ☐ Patient pick-up

REFILLS (circle one)

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DIRECTIONS/SIG + SIGNATURE

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☐ Other _____

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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