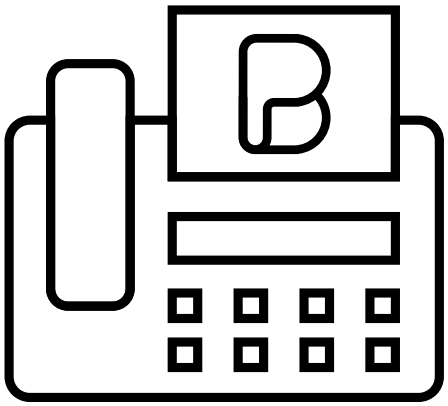
Bayview Pharmacy

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 – CUSTOM ORAL SUSPENSIONS

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

ANY MEDICATION – compounded to your order — **QUANTITY**

☐ Medication + concentration (mg/mL): _____ **QTY:** _____ mL

CONTROLLED SUBSTANCES CANNOT BE ORDERED ON THIS FORM – ketamine, methylphenidate, hydromorphone and clonazepam must be e-prescribed.

COMMONLY COMPOUNDED – write in the concentration — **QUANTITY**

☐ **GUA** Guanfacine suspension _____ mg/mL (0.25 / 0.5 / 1 / 1.5 / 2) **QTY:** _____ mL

☐ **LEU** Leucovorin suspension, anhydrous _____ mg/mL (2.5 / 5 / 10 / 15 / 20) **QTY:** _____ mL

☐ **OME** Omeprazole suspension _____ mg/mL (2 / 6 / 8 / 10) **QTY:** _____ mL

☐ **OME-C** Omeprazole 20 mg delayed-release capsules **QTY:** _____ caps

FORMULATION OPTIONS – apply to any selection above

Vehicle: ☐ Anhydrous (water-free) ☐ Aqueous ☐ Pharmacy's choice

Exclude: ☐ Dye-free ☐ Sugar-free ☐ Alcohol-free

Feeding tube: ☐ NG ☐ PEG ☐ G-tube ☐ Flush before and after

REFILLS (circle one)

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

DIRECTIONS/SIG + SIGNATURE

☐ Give _____ mL by mouth once daily.

☐ Give _____ mL by mouth 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 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 – ORAL LIQUIDS – MENTAL HEALTH

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

MENTAL HEALTH – Oral Liquid & Suspension	QUANTITY
☐ Quetiapine ____ mg/mL oral liquid (10 or 50 mg/mL) or 40 mg/mL suspension	**QTY:** ☐ 120 ☐ 240 ☐ 480 mL
☐ Duloxetine ____ mg/mL oral suspension (2 to 20 mg/mL)	**QTY:** ☐ 120 ☐ 240 ☐ 480 mL
☐ Bupropion ____ mg/mL oral liquid (15 to 150 mg/mL)	**QTY:** ☐ 120 ☐ 240 ☐ 480 mL
☐ Atomoxetine ____ mg/mL oral liquid (4 to 20 mg/mL)	**QTY:** ☐ 120 ☐ 240 ☐ 480 mL
☐ Trazodone 10 mg/mL oral liquid or suspension	**QTY:** ☐ 120 ☐ 240 ☐ 480 mL
☐ Sertraline ____ mg/mL oral liquid (1 to 2 mg/mL), 10 mg/mL suspension or 20 mg/mL concentrate	**QTY:** ☐ 120 ☐ 240 ☐ 480 mL
☐ Mirtazapine ____ mg/mL oral liquid (1 or 2 mg/mL)	**QTY:** ☐ 120 ☐ 240 ☐ 480 mL

An oral syringe is supplied with each liquid. Mark feeding-tube use in the directions.

MENTAL HEALTH – Feeding-Tube Liquid	QUANTITY
☐ Quetiapine 10 mg/mL feeding-tube liquid	**QTY:** ☐ 120 ☐ 240 ☐ 480 mL
☐ Bupropion ____ mg/mL feeding-tube liquid	**QTY:** ☐ 120 ☐ 240 ☐ 480 mL

DULOXETINE – Acid-Resistant Capsules	QUANTITY
☐ Duloxetine ____ mg acid-resistant capsule (2 mg to 60 mg)	**QTY:** ☐ 30 ☐ 60 ☐ 90 caps

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

☐ Take ____ mL by mouth ____ times daily.

☐ Give ____ mL via feeding tube ____ times daily. Flush tube before and after.

☐ Take 1 capsule by mouth ____ times 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.