NEW PRESCRIPTION ORDER FORM

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 and Prescription Information

Prescriber's Name		
Phone Number	Fax Number	
Street Adress		
City	State	ZIP
NPI	DEA	

Rx

Prescribing Form – VAGINAL – Bio-Identical HRT

Please compound:

○ **Estradiol (E2) 0.02% Vaginal Cream**
- ○ Apply/Insert 1gm HS for two weeks, then decrease to 2-3 times a week thereafter
- ○ Apply/Insert 1gm HS 2-3 times a week
- ○ Other _____

○ **Estriol (E3) Vaginal Cream** ○ **0.05%** ○ **0.1%**
- ○ Apply/Insert 1gm HS for two weeks, then decrease to 2-3 times a week thereafter
- ○ Apply/Insert 1gm HS 2-3 times a week

○ **Progesterone Suppository (in Cocoa Butter)** ○ **50mg** ○ **100mg** ○ **200mg** ○ **Other _____**
- ○ Insert 1 suppository HS

○ **Dehydroepiandrosterone (DHEA)**

Vaginal Suppository ○ 3.25mg ○ 6mg ○ 13mg ○ Other _____ ○ Insert 1 suppository HS

Vaginal Gel ○ **13mg/Gm** ○ **Other _____** ○ **Insert 1ml PV HS**

Reference Only – Needs to be electronically prescribed
Testosterone 0.2% Vaginal Gel Apply/Insert 1gm vaginally HS for 2 weeks, then decrease to 2-3 times a week thereafter

QTY: ○ 1 month ○ 2 months ○ 3 months ○ Other _____

Refills: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ Other: _____

X _____ _____
Prescriber's Signature Date

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

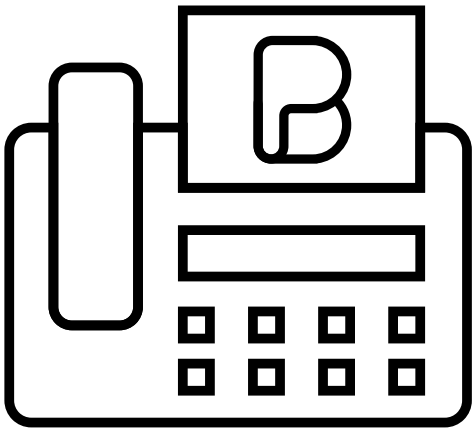
_____ _____
Pharmacy Name Pharmacy Fax Number

The pharmacy name & fax # cannot be pre-printed in order to comply with RI Law 216-RICR-40-15-1 section 1.3A10

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