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	

BI-MIX

- ○ Papaverine 30mg/ Phentolamine 1mg/ml (**Green**)
- ○ Papaverine 30mg/Phentolamine 2mg/ml (**Gold**)

ALPROSTADIL

- ○ Alprostadil 20mcg/ml (**Black**)
- ○ Alprostadil 40mcg/ml

TRI-MIX

- ○ Alprostadil 5mcg/ml/Papaverine 30mg/Phentolamine 1mg
- ○ Alprostadil 10mcg/ml/Papaverine 30mg/Phentolamine 1mg (**Blue**)
- ○ Alprostadil 20mcg/ml/Papaverine 30mg/Phentolamine 1mg (**Silver**)
- ○ Alprostadil 20mcg/ml/Papaverine 30mg/Phentolamine 2mg (**Red**)
- ○ Alprostadil 30mcg/ml/Papaverine 30mg/Phentolamine 1mg
- ○ Alprostadil 30mcg/ml/Papaverine 30mg/Phentolamine 2mg
- ○ Alprostadil 40mcg/ml/Papaverine 30mg/Phentolamine 1mg
- ○ Alprostadil 40mcg/ml/Papaverine 30mg/Phentolamine 2mg
- ○ Alprostadil 40mcg/ml/Papaverine 30mg/Phentolamine 3mg

QUAD-MIX

- ○ Alprostadil/Atropine/Papaverine/Phentolamine 20mcg-0.15-30mg-2mg/ml
- ○ Alprostadil/Atropine/Papaverine/Phentolamine 30mcg-0.15-30mg-2mg/ml

SYRINGES (#10 each)

29 gauge

- ○ 0.5ml x ½ "
- ○ 1ml x ½ "

30 gauge

- ○ 0.5ml x 5/16"
- ○ 1ml x 5/16"
- ○ 0.5ml x ½ "
- ○ 1ml x ½ "

VIAL SIZE

- ○ 1ml MDV
- ○ 2.5ml MDV
- ○ 5ml MDV

DISPENSING INSTRUCTIONS

- ○ Inject _____ml. If not desired result, dose may be increased in increments of _____ ml not to exceed _____ml.
- ○ Dose to be administered ___ times/week
- ○ Dose to be administered ___ times/day, No more than _____ times/week.
- ○ Other _____

Refills: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12 ○ Other _____

X _____ _____

Prescriber's Signature Date

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

_____ _____

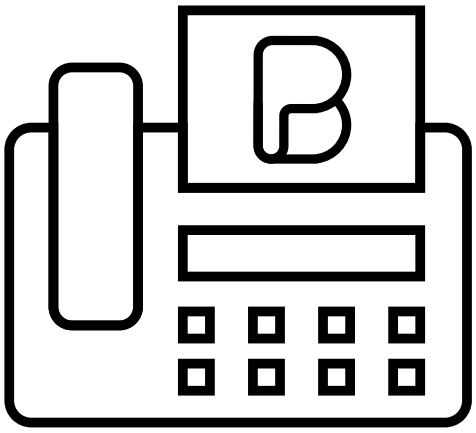
Pharmacy Name Pharmacy Fax Number

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