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 Address		
City	State	ZIP
NPI	DEA	

℞

Commonly Requested Formulas for Patients with Stretch Marks

- ○ Sodium Hyaluronate 0.5%/Tretinoin 0.025%/Aloe Vera 0.5% Topical Gel (PracaSil™-Plus)
- ○ Topiramate 2.5%/Aloe Vera 0.5% Topical Gel (PracaSil™-Plus)
- ○ Tretinoin 0.1% Topical Gel (PracaSil™-Plus)

Directions:

QTY: _____

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.

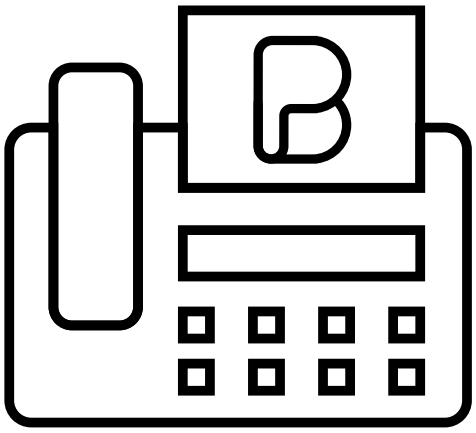
_____ _____
Pharmacy Name Pharmacy Fax Number

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