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 Vaginal Dryness

- ○ Estradiol 10 mcg Vaginal Suppository
- ○ Estriol 0.05% Vaginal Gel
- ○ Glycerin/Caprylic/Capric Triglycerides Suppository
- ○ Glycerin 15%/Vitamin E Acetate 0.2% Vaginal Gel
- ○ Hyaluronic Acid 5 mg/Gm Compound Vaginal Gel
- ○ Sodium Hyaluronate 5 mg/Gm Compound Vaginal Gel
- ○ Vitamin E 200 IU Vaginal Suppository
- ○ Vitamin E 200 u/Gm Vaginal Gel

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.

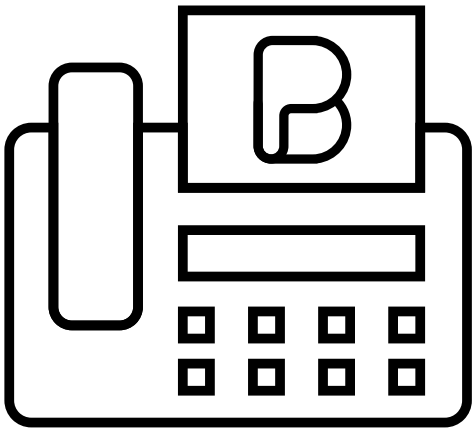
_____ _____
Pharmacy Name Pharmacy Fax Number

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