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 Diabetic Toes

- ○ Amitriptyline HCl 2%/Baclofen 2% Topical Lipoderm®
- ○ Amitriptyline HCl 2%/Baclofen 2%/Ketoprofen 10% Topical Lipoderm®
- ○ Amitriptyline HCl 2%/Ketoprofen 2%/Carbamazepine 2% Topical Lipoderm®
- ○ Ketoprofen 10%/Gabapentin 6%/Clonidine 0.2%/Nifedipine 2% Topical Lipoderm®
- ○ Ketoprofen 10%/Gabapentin 6%/Tizanidine HCl 0.2%/Nifedipine 2% Topical Lipoderm® ActiveMax™
- ○ Nifedipine 10%/Pentoxifylline 5%/Ketoprofen 10%/Gabapentin 6%/Lidocaine 3%/ Prilocaine 3% Topical Lipoderm® ActiveMax™

Directions: Apply 1-2ml's to affected area 3-4 times daily as needed

Other _____

QTY: ○80gm ○100gm ○150gm ○Other _____

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

_____
ICD10 Code*

X_____
Prescriber's Signature

_____
Date

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

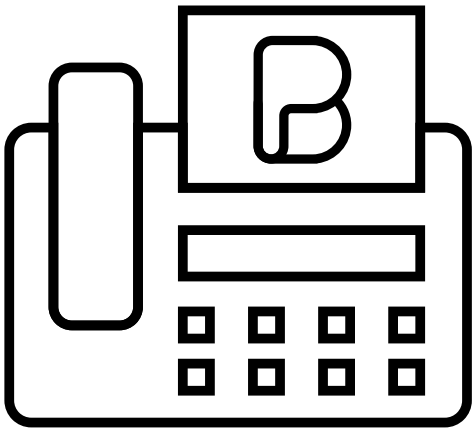
_____ _____
Pharmacy Name Pharmacy Fax Number

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