## **NEW PRESCRIPTION ORDER FORM**

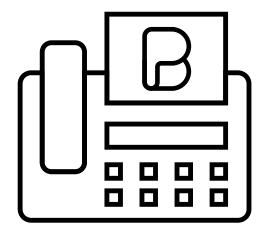
Patient Information							
Last Name	First Name			MI			
Address				Apt.#			
City	State ZIP		Phone Number				
Date of Birth (mm/dd/yyyy) Sex O			M O F Email				
O Patient will pick up at p	se ship to patient O Please ship to office						
2 Prescriber and Prescription	n Information	1	:				
Prescriber's Name							
Phone Number Fax Number							
Street Address							
City			State				
NPI			DEA				
Prescribing Form - Women	n's Health (3	of 4)					
Hair Loss (Women)	•		PCOSw	ith Excessive Hair (Hi	rsutism'	) & Acne	
○ Finasteride/Minoxidil/Tretinoin 0.1%-5%-Tretinoin			PCOS with Excessive Hair (Hirsutism) & Acne  O Progesterone 100mg ME4M Oral Capsule				
0.025% Topical Solution 60ml			O Take 1 capsule by mouth once daily at bedtime on days 14-25 of cycle				
○ Finasteride/Minoxidil 0.1%-							
○ Finasteride/Minoxidil/Tretir	Metformin HCI 10% Topical Cream						
0.1%-6%-0.01% 60ml	Apply topically to affected area(s) twice daily						
O Apply to affected area(s) of	Other	•					
O Other					<i>,</i> = :		
○ Minovidil/Spiropolesters 0	Topical FACIAL Cream Options (For Hirsutism)  ○ Azelaic Acid/Metformin HCI/Progesterone/ Spironolactone 1-5-1-5% Facial Cream  ○ Azelaic Acid/Metformin HCI/Progesterone 1-5-1% Facial Cream						
<ul> <li>Minoxidil/Spironolactone 0.</li> <li>Take 1 capsule by mouth one</li> </ul>							
QTY							
	○ Finasteride 0.25% Facial Cream						
	O Apply topically to affected area(s) twice daily						
				ther			
Defille 1 2 7 4 5 / 5	7 0 0 10	11 10/5:45	lo ons)				
Refills 1 2 3 4 5 6 7	0 9 10	II I∠(CIfC	ie orie)				
X Prescriber's Signature	Data						
				Date			
Fill out the Pharmacy Nar	ne and Fax n	umber, the	n fax it to tl	ne Pharmacy.			

Pharmacy Name Pharmacy Fax Number



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## **FAX COVER SHEET**



Please fax your order to:

401-284-4506

3844 Post Road, Warwick RI 02886

Phone: 401 - 284 - 4505

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