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	

○ Patient will pick up at pharmacy ○ Please ship to patient ○ Please ship to office

2 Prescriber and Prescription Information

Prescriber's Name		
Phone Number	Fax Number	
Street Address		
City	State	ZIP
NPI	DEA	

Prescribing Form – Women's Health (4 of 4)

Chronic Pelvic Pain (CPP)/Vaginismus/Painful Intercourse

- ○ **Amitriptyline HCl/Baclofen 2–2% Anhydrous Vaginal Cream (Ellage™)**
- ○ **Amitriptyline HCl/Gabapentin/Lidocaine 2–6–2% Anhydrous Vaginal Cream (Ellage™)**
  - ○ Apply/Insert 1gm intravaginally _____ times daily
  - ○ Other _____
    _____

Rosacea

- ○ **Azelaic Acid/Metronidazole 15–1.2% Anhydrous Topical Gel (PermE8™/WO6™)**
- ○ **Ivermectin/Ketotifen 1–0.05% Topical Cream**
- ○ **Ketotifen 0.05% Topical Cream**
- ○ **Ivermectin/Metronidazole 1–0.75% Anhydrous Topical Gel (PermE8™/WO6™)**
- ○ **Metronidazole/Ketotifen 0.75–0.05% Topical Cream**
  - ○ Apply topically to affected areas twice a day
  - ○ Other _____
    _____

Chronic Pelvic Pain (CPP)/Vaginismus/Painful Intercourse – Controlled Substances

requires the prescription to be **ELECTRONICALLY PRESCRIBED** because the formulation contains a controlled substance.

CREAM OPTIONS

Diazepam/Ketamine/Lidocaine 1–5–5% Anhydrous Vaginal Cream (Ellage™) (60gm)
Apply/Insert 1gm intravaginally __ times daily

Baclofen/Diazepam/Gabapentin/Lidocaine 2–1–6–2% Anhydrous Vaginal Cream (Ellage™)
Apply/Insert 1gm intravaginally __ times daily

VAGINAL SUPPOSITORY OPTIONS

Diazepam Vaginal Suppository
(Available Strengths 2.5mg, 5mg and 10mg**)**

Baclofen/Diazepam/Lidocaine 2%–5mg–2% Vaginal Suppository

Diazepam/Ketamine HCl/Lidocaine 1mg–30mg–30mg Vaginal Suppository
Insert 1 suppository intravaginally ___ times daily as needed

Refills 1 2 3 4 5 6 7 8 9 10 11 12 (circle one)

X_____ _____
Prescriber's Signature Date

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

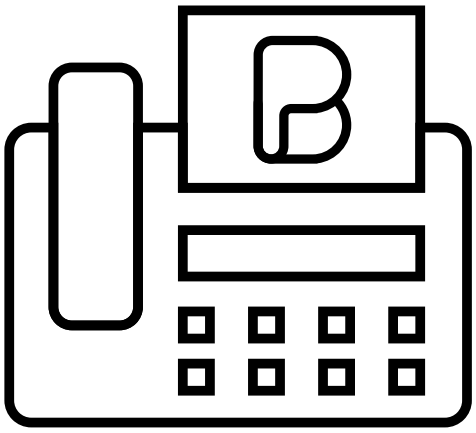
_____ _____
Pharmacy Name Pharmacy Fax Number

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