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

- ○ Ketoprofen 10% / Gabapentin 6% / Clonidine 0.2% / Nifedipine 2% Topical Lipoderm®
- ○ Nifedipine 4% Topical Lipoderm®
- ○ Nifedipine 16% Topical Lipoderm®
- ○ Nifedipine 10% / Pentoxifylline 5% / Ketoprofen 10% / Gabapentin 6% / Lidocaine 3%/ Prilocaine 3% Topical Lipoderm® ActiveMax™
- ○ Pentoxifylline 3% / Nifedipine 3% Topical Lipoderm®
- ○ Pentoxifylline 5% Topical Lipoderm®
- ○ Pentoxifylline 5% / Nifedipine 2% Topical Lipoderm®

Commonly Requested Formulas for Patients with Circulation Problems or Raynaud's Phenomenon

- ○ Nifedipine 4% Topical Lipoderm®
- ○ Pentoxifylline 5% / Nifedipine 2% Topical Lipoderm®
- ○ Pentoxifylline 3% / Nifedipine 3% Topical Lipoderm®
- ○ Pentoxifylline 5% Topical Lipoderm®
- ○ Nifedipine 16% Topical Lipoderm®

Directions: Apply 1ml to affected area 3-4 times daily

QTY: ○ 60gm ○ 120gm ○ Other _____

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.

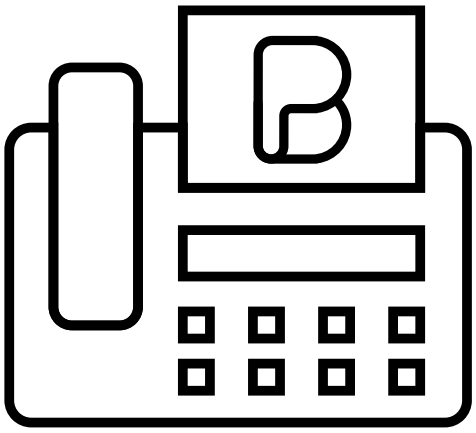
_____ _____
Pharmacy Name Pharmacy Fax Number

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