# 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 Female Sexual Dysfunction/Libido**

- ○ Dehydroepiandrosterone 13 mg/Gm Vaginal Gel
- ○ Oxytocin 120 U/Gm Vaginal Gel
- ○ Papaverine HCl 0.1%/Arginine 6% Topical Cream
- ○ Sildenafil 2%/Theophylline 2.5%/Arginine HCl 6% Topical Cream

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.

_____ _____

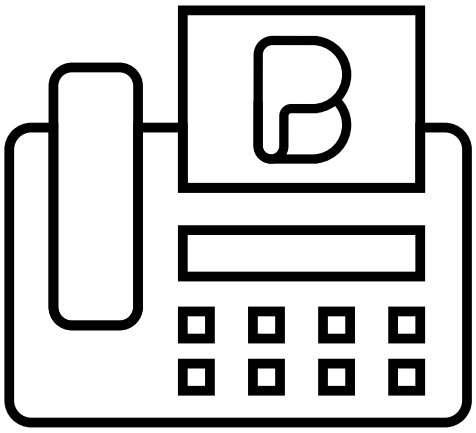
Pharmacy Name Pharmacy Fax Number

*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