

# 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        | <input type="radio"/> M <input type="radio"/> 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 Eosinophilic Esophagitis (EOS) or Eosinophilic Colitis

- ☐ Budesonide 1 mg/10 mL to 2 mg/10 mL Oral Suspension
- ☐ Montelukast 1 mg/ml/Ketotifen 0.5 mg/ml/Budesonide 0.5 mg/ml Oral Suspension
- ☐ Montelukast 1 mg/ml/Ketotifen 0.5 mg/ml/Budesonide 0.5 mg/ml/Quercetin 10mg/ml Oral Suspension

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

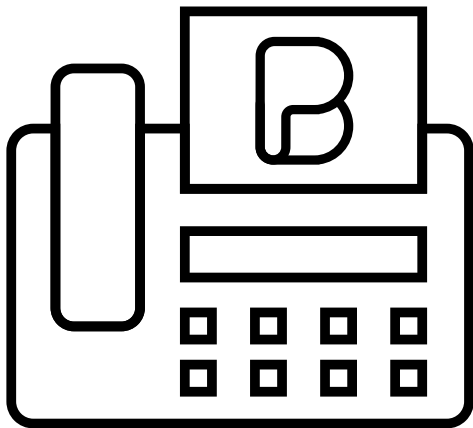
*The pharmacy name & fax # cannot be pre-printed in order to comply with RI Law 216-RICR-40-15-1 section 1.3A10*



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# FAX COVER SHEET



Please fax your order to:

**401-284-4506**

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3844 Post Road, Warwick RI 02886

Phone: 401 - 284 - 4505

[www.bayviewrx.com](http://www.bayviewrx.com)