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 Warts

- ○ Cantharidin 1% Topical Liquid 5ml (in office only)
- ○ Cantharidin 1%/Salicylic Acid 30%/Podophyllum 5% Topical Liquid 5ml (in office only)
- ○ Cimetidine 10%/Deoxy-D-Glucose 0.29%/Ibuprofen 2% Topical Lipoderm®
- ○ Cimetidine 10%/Deoxy-D-Glucose 0.2%/Ibuprofen 2%/Lidocaine 5%/Salicylic Acid 15% Topical Occlusaderm®
- ○ Deoxy-D-Glucose 0.2%/Imiquimod 5%/Tea Tree Oil 2.5%/Cimetidine 10% Topical Cream
- ○ Imiquimod 5%/Deoxy-D-Glucose 0.2% Topical Gel (PracaSil™-Plus)
- ○ Salicylic Acid 16.67% Compound Collodion Topical
- ○ Salicylic Acid 40% Topical Ointment
- ○ Squaric Acid Dibutyl Ester 0.1% Topical Solution
- ○ Salicylic Acid 15%/Cimetidine 5% Topical Occlusaderm®
- ○ Podophyllum 20% In Tincture of Benzoin (15ml)

Directions:
- ○ Apply to wart(s) twice daily
- ○ Other _____

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.

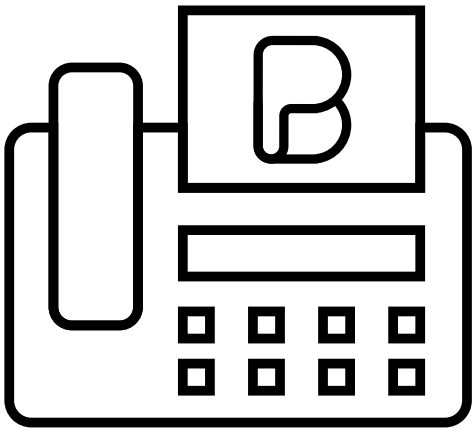
_____ _____
Pharmacy Name Pharmacy Fax Number

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