

[Your Practice Name]
[Your Practice Address]
[City, State, Zip Code]
[Phone Number]
[Fax Number]
[Date]
[Patient's Name]
[Patient's Address]
[City, State, Zip Code]
[Patient's Date of Birth]
[Patient's Insurance Information]
Prescription
Patient Name: [Patient's Name]
Date of Birth: [Patient's Date of Birth]
Medication: Vyvanse
Dosage: [Dosage in mg]
Directions: [e.g., Take one capsule by mouth once daily in the morning]
Refills: [Number of refills]
Provider: [Your Name, MD/DO/NP/PA]
NPI Number: [Your NPI Number]
Signature: _____
Date: [Date]
[Additional Notes/Instructions if necessary]