[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]
[Date]
[Pharmacy Name]
[Pharmacy Address]
[City, State, Zip Code]
Dear [Pharmacist's Name or "To Whom It May Concern"],
RE: Prescription for Vyvanse
Patient Name: [Patient's Full Name]
Date of Birth: [Patient's Date of Birth]
Patient ID: [Patient's ID or medical record number if applicable]
Prescription Details:
Medication: Vyvanse
Dosage: [Dosage Amount]
Quantity: [Number of tablets]
Refills: [Number of refills]
Instructions:
- Take [Dosage] once daily in the morning.
- [Additional dosage instructions or special instructions].
Diagnosis Code: [ICD Code if applicable]
Prescribing Physician:
[Your Full Name]
[Your Medical License Number]
[Your Practice Name]
[Your Practice Address]
[Your Practice Phone Number]
Sincerely,
[Your Signature]
[Your Printed Name]
[Your Title/Position]