[Your Name]
[Your Title/Position]
[Your Practice/Clinic Name]
[Practice Address]
[City, State, ZIP Code]
[Phone Number]
[Email Address]
[Date]
[Pharmacy Name]
[Pharmacy Address]
[City, State, ZIP Code]
Patient Name: [Patient's Full Name]
Patient Date of Birth: [MM/DD/YYYY]
Patient Address: [Patient's Address]
Rx: Vyvanse
Strength: [Specify Strength, e.g., 30 mg]
Dosage Form: [e.g., Capsule]
Quantity: [e.g., 30 capsules]
Directions: Take [e.g., one capsule] by mouth once daily in the morning.
Refills: [Number of Refills]
Prescriber Signature: _____
[Your Name, MD/DO/NP/PA]
NPI Number: [Your NPI Number]