116 Village Blvd., Suite 200
Princeton, New Jersey
08540 U.S.A

Medicure Replacement / Return Information Form

Please read the Notes on page 2 before you complete this form.

- **Please Select from below options:**

☐ Replacement ☐ Return and refund

Please fill out the information below:

CONTACT INFORMATION		
Select one: ☐ Hospital Pharmacy ☐ Gov. Pharmacy ☐ Private Pharmacy		
Name:		Title:
Phone:	Fax:	Email Address:

HOSPITAL/PHARMACY SHIPPING INFORMATION			
Hospital/Pharmacy Name:	DEA:	Wholesaler:	
Pharmacy State License Number: *(Please attach a copy of hospital license to this form)*:	Pharmacy State License Expiry date:		
Address *(will not ship to a P.O. Box)*:	City:	State:	Zip:

RETURNED PRODUCT			
NDC:	Lot:	Expiry Date:	Quantity:
NDC:	Lot:	Expiry Date:	Quantity:
NDC:	Lot:	Expiry Date:	Quantity:
NDC:	Lot:	Expiry Date:	Quantity:
NDC:	Lot:	Expiry Date:	Quantity:
NDC:	Lot:	Expiry Date:	Quantity:
NDC:	Lot:	Expiry Date:	Quantity:

HOSPITAL/PHARMACY AUTHORIZATION		
Authorized By:	Signature:	Date:
Debit Memo # *(Medicure uses this number for tracking purposes)*:		

PLEASE NOTE

- The completed form must be accompanied by a Valid copy of the hospital's state license. The request for a
- replacement product will be denied if no copy is provided.
- In case the Debit Memo number cannot be provided, please use the following format:
- HRO < DEA NUMBER > (Example: HROBB5573352).
- Returned product must be received by Medicure no later than 60 days from the time of replacement
- authorization.
- If the returned product is received after 60 days from time of authorization time, NO replacement product will be shipped.
- Medicure Replacement policy: 180 days prior to the expiry date or 180 days after the expiry date.
- Medicure Return and refund policy: 180 days prior to the expiry date or 180 days after the expiry date.

Please refer to Medicure Pharma's Hospital Return Goods Policy for more information.

Thank you for completing!

Please email or fax to the Medicure Order Fulfillment Center:

Fax: 1.614.553.9260
Email: GMB-SPS-ReturnRequests@cordlogistics.com

MEDICURE AUTHORIZATION (do not fill out)		
Authorized By:	Signature:	Date: