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

Medicure Replacement Information Form

When completed, please email or fax to the Medicure Order Fulfillment Center:
Fax: **1.614.553.9260**
Email: **GMB-SPS-ReturnRequests@cordlogistics.com**

Please fill out the information below:

CONTACT INFORMATION

Name:		Title:
Phone:	Fax:	Email Address:

HOSPITAL/PHARMACY SHIPPING INFORMATION

Hospital/Pharmacy Name:	DEA:	Wholesaler:	
Address *(will not ship to a P.O. Box)*:	City:	State:	Zip:

RETURNED PRODUCT

NDC:	Lot:	Expiration Date:	Quantity:
NDC:	Lot:	Expiration Date:	Quantity:
NDC:	Lot:	Expiration Date:	Quantity:

HOSPITAL/PHARMACY AUTHORIZATION

Authorized By:	Signature:	Date:
Debit Memo # *(Medicure uses this number for tracking purposes)*:	Hospital/Pharmacy State License # *(attach copy of hospital license to this form)*:	

PLEASE NOTE

This completed form must be accompanied by a copy of the hospital's state license. If no copy is provided, the request for replacement product will be denied.
If a debit memo number cannot be provided, then use the following format: HRO<**DEA NUMBER**> (example: HRO**BB5573352**)
Returned product must be received by Medicure no later than 60 days from time of replacement authorization. If returned product is received greater than 60 days from time of authorization, no replacement product will be shipped.

MEDICURE AUTHORIZATION *(do not fill out)*

Authorized By:	Signature:	Date:

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