

# PRODUCT RETURN FORM

**(Form Must be Included With the Return)**

\*ALL RETURNS ARE SUBJECT TO BOTH THE MERCK & CO., INC. TERMS AND CONDITIONS PHARMACEUTICAL PRODUCTS AND THE MERCK & CO., INC. TERMS AND CONDITIONS OF SALE VACCINE PRODUCTS\*

**Section 1: Primary Information for Customer Making the Return**

Date of Return: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

\* DEA# (Optional) 

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|

Number of Boxes/Cartons Used to Ship This Return: \_\_\_\_\_

HIN # (Optional) \_\_\_\_\_

**Section 2: Direct Customers Only** (Product was purchased directly from Merck & Co. Inc.) (If you DID NOT purchase your product directly from Merck & Co., Inc., please proceed to Section 3)

Merck Account #: \_\_\_\_\_

PO# / Debit Memo #: \_\_\_\_\_

Enter Your Account Name and Address

|                  |  |
|------------------|--|
| Name             |  |
| Address          |  |
| City, State, Zip |  |

*(When finished with section 2, proceed to section 4 below)*

**Section 4: Mailing Instructions**

**REQUIRED:** Include an itemized Packing List containing the Product Name, Lot or Control Number, and Quantity of each product being returned.

**SEND PACKING LIST AND RETURN PRODUCT TO:**

**For Direct Mailers and Parcel Post Delivery:**

PharmaReturns, Inc. Processing Center  
P.O. Box 1077  
Montgomeryville, PA 18936-1077

**For Package And Pallet Shipments:**

PharmaReturns, Inc. Processing Center  
100 Corporate Drive, Suite 2  
Montgomeryville, PA 18936-9644

**Section 3: Indirect Customers Only** (Product was purchased from a Distributor or Wholesaler)

HIN #: \_\_\_\_\_

PO# / Debit Memo #: \_\_\_\_\_

Enter Your Business Name and Address

|                  |  |
|------------------|--|
| Name             |  |
| Address          |  |
| City, State, Zip |  |

Mail Reimbursement to: *(if different from Business Address Shown Above)*

|                  |  |
|------------------|--|
| Address          |  |
| City, State, Zip |  |

Enter Name and Address of the Distributor/Wholesaler from which you purchased the product:

|                  |  |
|------------------|--|
| Name             |  |
| Address          |  |
| City, State, Zip |  |

**THIS PRODUCT IS NOT FOR RESALE**

\* By filling out and submitting this form to PharmaReturns, Inc., Customer authorizes PharmaReturns, Inc. and Merck & Co., Inc. to release the DEA registration number provided above as necessary to process product returns. Failure to supply this information or another identification number could lead to delay in processing.

You may contact the Order Management Center with your questions, Monday through Friday, 8AM - 6PM EST, excluding holidays.  
Phone: 1 800-637-2579 (800 MERCKRX) Fax: 1-215-631-5995