



## Revolution® Satisfaction Guarantee Request Form

If you are not completely satisfied with Revolution\*, the product will be replaced or the purchase price refunded. Guarantee applies to current product purchased from a veterinary hospital only.

Contact Information
Name: _____
Street/PO Box: _____
Apt/Ste#(if applicable: _____
City: _____
State: _____ Zip Code: _____
Case Number (required): 20__ __ US _____

  

Veterinary Information
Clinic Name: _____
Attending Veterinarian: _____
Zip Code: _____ Phone Number: _____

  

Treatment Information** (select all that apply)
<b>Cat:</b> <input type="checkbox"/> Fleas <input type="checkbox"/> Ear Mites <input type="checkbox"/> Other _____
<b>Dog:</b> <input type="checkbox"/> Fleas <input type="checkbox"/> Ear Mites <input type="checkbox"/> Sarcoptic Mange <input type="checkbox"/> Ticks <input type="checkbox"/> Other _____

  

Purchase information: (select all that apply)
<input type="checkbox"/> Puppy/Kitten up to 5 lbs <input type="checkbox"/> Cat 5.1-15 lbs <input type="checkbox"/> Dog 20.1-40lbs
<input type="checkbox"/> Dog 5.1-10lbs <input type="checkbox"/> Dog 40.1-85lbs <input type="checkbox"/> Dog 10.1-20lbs
<input type="checkbox"/> Dog 85.1-130lbs

\*Subject to program requirements  
\*\* This form does not apply to requests pertaining to intestinal parasites or heartworm infection. Medical records may be required for these cases. Please have your veterinarian contact Pfizer at 1-800-366-5288 with the case number.

**Reimbursement:** (select **one** of the following options)

**Options** (select one of the following):

- Free dose of Revolution<sup>®</sup> (free dose will be arranged through your veterinary clinic)
- \$15.00 towards an alternative treatment
- Reimbursement of last purchase\*

\*Any unused product needs to be returned to your veterinary clinic prior to reimbursement.

**Method** (select one of the following):

**Check Payable to:**

- Yourself/Pet Owner
- Veterinary Clinic

- Credit to Veterinary Clinic** (Veterinary Clinic will be contacted to process credit)

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**In order to process your request, a copy of the invoice for your most recent purchase of Revolution<sup>®</sup> from your veterinarian must be included. Please retain a copy of all submitted materials for your records.**

**Mail all appropriate documents using the envelope provided to:**  
(Fold form so that address is showing through window of envelope)

**Pfizer Inc  
Attn: VMIPS  
812 Springdale Dr.  
Exton, PA 19341**

**Or fax to: (866) 590-1149**

---Fold Here---

**I verify that the information provided is accurate.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**