



RECALL STOCK RESPONSE FORM
RECALL of INFeD® Iron Dextran Injection 50 mg/ml
(Retail Level) (12/18/2017)

Please fill out this form completely. By doing so, this will acknowledge that you have read and understand the recall instructions and have taken the appropriate action.

Customer Name _____ DEA # _____
**DEA # is required, if it is not provided, the processing of your form will be delayed.*

Address _____

City _____ State _____ Zip _____

Contact Name (please print) _____ Telephone # _____

Contact Signature _____ Date _____

I have checked my stock and:

_____ Do not have any stock of the recalled **items**.

OR

I have quarantined and listed in the box below the quantity of recall units and I will be returning to Inmar, as soon as possible. Upon receipt of this Response Form, Inmar, will issue return authorization label(s) Please indicate the # of needed box labels _____.

Item Description	NDC	Lot #	Qty returning
INFeD® Iron Dextran Injection 50 mg/ml	52544-931-02	15W05A	
		17W01A	
		16W02A	
		16W05A	
		16W13A	
		17W02A	
		17W09A	
		17W15A	
		16W15A	
		16W16A	
		16W17A	
		16W18A	
		16W20A	
		16W22A	
		17W04A	
		17W05A	
		17W11A	
17W13A			
17W14A			

If you did not purchase the product directly from the Manufacturer, please complete the below section.

Purchased From: Wholesaler Name _____ DEA # _____

City _____ State _____

If you have any questions regarding this form or product return please contact Inmar at 1-800-967-5952. Office hours 9am to 5pm EST Mon thru Fri.

Please fax this form to: 1-817-868-5362 or E-mail rxrecalls@inmar.com