

RECALL STOCK RESPONSE FORM

**Brimonidine Tartrate/Timolol Maleate Ophthalmic Solution
(Retail / Pharmacy Level) (05/28/2025)**

Please fill out this form completely. By doing so, this will acknowledge that you have read and understood 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 #: _____

Email: _____ Contact Signature: _____ Date: _____

Wholesaler Information if not directly purchased from Apotex:

Name: _____ DEA #: _____

City: _____ State: _____ ZIP: _____

I/We, have checked our stock and confirm that:

- ☐ Do not have any stock of the recalled **lot**.
- ☐ I have quarantined and listed in the box(es) 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 required box labels _____.

☐ I confirm that all locations that have received the identified lot have been notified to the Retail / Pharmacy level _____.
(Initial and date)

Please see following table and indicate amount of product you have on hand in the appropriate column / row of the table.

| Product | Strength | Pack Size (Bottle) | NDC | UPC on Bottle | UPC on Carton | Lot Number | Expiry Date (mm/yyyy) | Qty. of Full Bottles to return | Qty. of Partial Bottles to return |
|--|---------------|--------------------|--------------|----------------------|---------------|------------|-----------------------|--------------------------------|-----------------------------------|
| Brimonidine Tartrate/Timolol Maleate Ophthalmic Solution | 0.2%/ 0.5% | 15 mL | 60505-0589-3 | (01)0(03)60505058938 | 360505058938 | VC6058 | 10/2025 | | |

If you have any questions regarding this form or product return, please contact Inmar at 1-855-244-7257. Office hours 9am to 5pm EST Mon through Fri.

Please return this form by E-mail rxrecalls@inmar.com or by fax to: 1-817-868-5362 or by mail to Inmar, Attn: Recall Coordinator, Inmar, One West Fourth Street, Suite 500, Winston Salem, NC 27101