



RETURN RESPONSE FORM
Wholesale/Distributor & Retail Pharmacy Level Market Withdrawal
October 6, 2026

Please complete and return this form immediately by FAX 1-817-868-5362 or email to HikmaEvent@inmar.com.

Please check ALL appropriate boxes:

☐ I have read and understand the instructions provided in the enclosed **Abirtega™ (abiraterone acetate tablets, USP), 250 mg** and **Abiraterone Acetate Tablets, USP, 250 mg** market withdrawal packet.

☐ I **have** checked my stock of the withdrawn product listed below and have quarantined inventory and will be returning the number of units shown below. Upon receipt of this Return Response Form, **Inmar Rx Solutions, Inc.**, will issue return authorization shipping label(s) and a return kit.

Please indicate the number of needed box labels _____.

☐ I **do not have** any stock of the below withdrawn product and will not be making a return.

☐ I **have** informed all of my customers of the Retail Level Market Withdrawal.

Market Withdrawal Product: Abirtega™ (abiraterone acetate tablets, USP), 250 mg

Product Packaging: Bottles of 120				NDC No. 82249-011-12			
Ship Dates: 09/19/2025 to 11/05/2025							
Lot No.	Exp. Date	Total Full Units (sealed)	Total Partial Units (opened)	Lot No.	Exp. Date	Total Full Units (sealed)	Total Partial Units (opened)
3046	July 2027			3050	August 2027		
3048	August 2027			3051	August 2027		
3049	August 2027			3052	August 2027		

Market Withdrawal Product: Abiraterone Acetate Tablets, USP, 250 mg

Product Packaging: Bottles of 120				NDC No. 0143-9597-21			
Ship Dates: 09/18/2025 to 01/15/2026							
3053	August 2027			3059	August 2027		
3054	August 2027			3060	August 2027		
3055	August 2027			3061	August 2027		
3056	August 2027			3062	August 2027		
3057	August 2027			3063	August 2027		
3058	August 2027			3064	August 2027		

Company Name: _____ DEA#: _____

**DEA # is required, if not provided the processing of your form may be delayed.*

Address: _____ City: _____

State: _____ Zip: _____ Phone Number: _____

Fax Number: _____ Email Address: _____

Contact Name: (please print) _____

Contact Name Signature: _____ Date: _____



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If you did not purchase the product directly from Hikma Pharmaceuticals USA Inc. (Formerly West-Ward Pharmaceuticals Corp.) please complete the below section:

Purchased From Wholesaler Name: _____ DEA #: _____

City: _____ State: _____ Zip: _____

- If you have any questions regarding this form or product return please contact **Inmar Rx Solutions, Inc.** at 1-855-319-6612 during office hours from 9:00am to 5:00pm EST, Monday through Friday.
- Please send this form to **Inmar Rx Solutions, Inc.** by FAX: 1-817-868-5362 or E-mail: HikmaEvent@inmar.com.