

## PRODUCT RECALL RESPONSE FORM

### URGENT DRUG RECALL – RETAIL LEVEL

Please complete the required information and fax it to **1-817-868-5362**  
or email to [rxrecalls@inmar.com](mailto:rxrecalls@inmar.com)

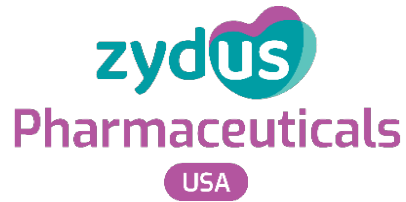
**To the Attention of Drug Safety/ Recall Services-Zydus Pharmaceuticals USA Inc.**

Product	Vial NDC Number	Carton NDC Number	Lot Number	Expiry Date	No. of Vials/Boxes Purchased	No of the Vials/Boxes consumed	No. of Vials/Boxes in possession	No of Vials/Boxes to be returned
Succinylcholine Chloride injection 20 mg/mL	70710-1377-1	70710-1377-2	L400077	08/2025				
Succinylcholine Chloride injection 20 mg/mL	70710-1377-1	70710-1377-2	L400113	09/2025				
Succinylcholine Chloride injection 20 mg/mL	70710-1377-1	70710-1377-2	L400372	03/2026				
Succinylcholine Chloride injection 20 mg/mL	70710-1377-1	70710-1377-2	L400373	03/2026				
Succinylcholine Chloride injection 20 mg/mL	70710-1377-1	70710-1377-2	L400374	04/2026				

**Office of Regulatory Affairs**  
**Zydus Pharmaceuticals (USA) Inc.**

(A wholly owned subsidiary of Zydus Lifesciences Limited)

73 Route 31 North • Pennington, NJ 08534 | Phone: 609-730-1900 | Fax: 609-730-1999



No. of Returns kit required: \_\_\_\_\_

Please mark as applicable

We currently do not have any inventory of the above-listed Lot/bottles

We are notifying our customers

We have identified and notified my customers that were shipped or may have been shipped this product by \_\_\_\_\_;

Attached is the list of customers who received/ may have received this product. Please notify my customers.

Any adverse event associated with recalled product?  Yes  No

If yes, please explain:

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Please check appropriate box to describe your business

Wholesaler/Distributor

Retailers

Repackager

Manufacturer

Pharmacy- Retail

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# Pharmaceuticals

USA

\_\_\_ Hospital/ Medical Facility

\_\_\_ Hospital Pharmacies

\_\_\_ Medical Laboratory

\_\_\_ Other: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Tel Number: \_\_\_\_\_

Firm Name: \_\_\_\_\_

DEA# \_\_\_\_\_

Address: \_\_\_\_\_

City/ State: \_\_\_\_\_

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

If you have not purchased, the concerned lot directly from Zydus Pharmaceuticals USA Inc., then please provide details of your wholesaler: \_\_\_\_\_ (Name, City) DEA# \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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