Sun Pharmaceuticals Industries, Inc.

URGENT: DRUG RECALL – RESPONSE FORM

Perampanel 6mg tablet, CIII

Retail Level

6/17/2026

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#:	Email:	
Contact Signature:	Date:	

DEBIT MEMO# (If unsure, leave blank):

Wholesaler Information if not directly purchased from Sun Pharma:

Wholesaler Name:	DEA#:	
City:	State:	Zip:

I have checked my stock and communicated to my customers at the appropriate level:

- ☐ I confirm that all locations that received the impacted products have been notified to the **Retail level** _____(Initial and date)
- ☐ I do not have any stock of the recalled items. **OR**

  ☐ I have quarantined and listed in the box below the quantity of recalled 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_____.

Product Name	Package Description	NDC#	Lot#	Expiration Date	Total Number of Units (number of full cartons) or prescription packs (partial cartons)
Perampanel 6mg tablet	30 ct bottle	51672-4206-6	AE01763	9/30/2027	

If you have any questions regarding this form or product return please contact Inmar Inc. at Rxrecalls@Inmar.com or call **855-792-9070** Monday to Friday from 8:30 am to 5:00 pm (EST).

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