

RECALL RETURN RESPONSE FORM

URGENT DRUG RECALL - RETAIL LEVEL

Product and Strength	NDC Number	Lot Number	Exp. Date
Icosapent Ethyl Capsules 1 g	70710-1592-7	B237040	10/2025
Icosapent Ethyl Capsules 1 g	70710-1592-7	B237041	10/2025

Please check ALL appropriate boxes.

- ☐ I have read and understand the recall instructions provided in the May 30, 2025 letter.
- ☐ I have checked my stock and have quarantined inventory consisting of _____ bottles.

Indicate disposition of recalled product:

- ☐ returned (**specify quantity, date and method**)/held for return;
- ☐ I have identified and notified my customers that were shipped or may have been shipped this product by (**specify date and method of notification**); <or>
Attached is a list of customers who received/may have received this product. Please notify my customers.

Any adverse events associated with recalled product? ☐ Yes ☐ NO

If yes, please explain: _____

Please check the appropriate box(es) to describe your business

- ☐ wholesaler/distributor ☐ retailer
- ☐ grocery corporate headquarters
- ☐ repacker ☐ manufacturer
- ☐ pharmacy ☐ retail ☐ hospital/medical facility ☐ hospital pharmacies ☐ medical laboratory
- ☐ Other: _____

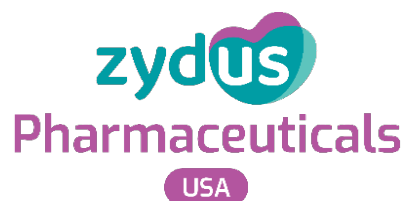
Office of Regulatory Affairs

Zydus Pharmaceuticals (USA) Inc.

(A wholly owned subsidiary of Zydus Lifesciences Limited)

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





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: _____

Inmar Rx Solutions (on behalf of Zydus Pharmaceuticals (USA) Inc.)

Please complete the required information and fax it to **1-817-868-5362**

or email to rxrecalls@inmar.com

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