



## **URGENT: DRUG RECALL – RESPONSE FORM**

**Please Complete This Form and Fax to: 817-868-5362**

**or Email to: [rxrecalls@inmar.com](mailto:rxrecalls@inmar.com)**

Product Name	Lot Numbers	NDC Number
Metformin HCl Extended-Release Tablets, USP, 500 mg (500 Count)	JKX2949A, JKX2803A, JKX2804A, JKX2805A, JKX2806A, JKX2945A, JKX2946A, JKX2947A, JKX2948A, JKX2952A, JKX2953A, JKX2954A, JKX3224A, JKX3211A, and JKX3212A	62756-142-02

**Please check ALL appropriate boxes.**

☐ I have read and understand the recall instructions provided in the April 30, 2021 letter.

☐ I have checked our stock and have quarantined inventory consisting of \_\_\_\_\_ units.

☐ Indicate disposition of recalled product:

☐ returned (**specify quantity, date and method**)/held for return;

Number of Labels Required for Return to Inmar: \_\_\_\_\_

☐ previously destroyed (**specify quantity, date and method**);

☐ I have identified and notified my retail customers that were shipped or may have been shipped this product by (**specify date and method of notification**); or

☐ Attached is a list of retail 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: \_\_\_\_\_

For return of affected product, please email [rxrecalls@inmar.com](mailto:rxrecalls@inmar.com) or call 1-855-696-0408.



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Metformin HCl Extended-Release Tablets, USP, 500 mg	500 Count	JKX2949A, JKX2803A, JKX2804A, JKX2805A, JKX2806A, JKX2945A, JKX2946A, JKX2947A, JKX2948A, JKX2952A, JKX2953A, JKX2954A, JKX3224A, JKX3211A, and JKX3212A

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

- |   |  |
|---|--|
| <input type="checkbox"/> wholesaler/distributor         | <input type="checkbox"/> retailer                  |
| <input type="checkbox"/> grocery corporate headquarters | <input type="checkbox"/> hospital pharmacies       |
| <input type="checkbox"/> repacker                       | <input type="checkbox"/> hospital/medical facility |
| <input type="checkbox"/> pharmacy                       | <input type="checkbox"/> Other:                    |

Customer Name: \_\_\_\_\_ Title: \_\_\_\_\_

Company: \_\_\_\_\_ DEA Number: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Customer Debit Memo Number: \_\_\_\_\_

Wholesaler: \_\_\_\_\_ City\State: \_\_\_\_\_

Wholesaler DEA Number: \_\_\_\_\_

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