APOTEX
Canadian-Based
Global Health Company

RECALL STOCK RESPONSE FORM

Desmopressin Nasal Spray, USP
(Retail / Pharmacy Level) (04/08/2026)

Please fill out this form completely. By doing so, this will acknowledge that you have read and understood 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: _____

Wholesaler Information if not directly purchased from Apotex:

Name: _____ DEA #: _____

City: _____ State: _____ ZIP: _____

I/We, have checked our stock and confirm that:

☐ Do not have any stock of the recalled **lot**.

☐ I have quarantined and listed in the box(es) below the quantity of recall 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 required box labels _____.

☐ I confirm that all locations that have received the identified lots have been notified to the Retail / Pharmacy level _____.
(Initial and date)

Please see following table and indicate amount of product you have on hand in the appropriate column / row of the table.

Product	Strength	Pack Size (Bottle)	NDC	UPC on Bottle	UPC on Carton	Lot Number	Expiry Date (mm/yyyy)	Qty. of Full Bottles to return	Qty. of Partial Bottles to return
Desmopressin Nasal Spray, USP	10mcg/0.1 mL	5 mL	60505-0815-0	(01)00360505081509	00360505081509	VM4231	06/2027		

If you have any questions regarding this form or product return, please contact Inmar at 1-877-411-4286. Office hours 9am to 5pm EST Mon through Fri.

Please return this form by E-mail rxrecalls@inmar.com or by fax to: 1-817-868-5362 or by mail to Inmar Pharmaceutical Services, Attn: Recall Coordinator - One West Fourth Street, Suite 500, Winston Salem, NC 27101