

Sun Pharmaceuticals Industries, Inc.

URGENT: DRUG RECALL – RESPONSE FORM DOXOrubicin Hydrochloride Liposome Injection

(This is a marketed product under the Aisling label)

HOSPITAL/USER LEVEL

5/12/2026



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 **Hospital/User 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	Input Product to return
DOXOrubicin Hydrochloride Liposome Injection	25 mL in 1 VIAL	72603-200-01	HAG2581B	05/2027	

If you have any questions regarding this form or product return please contact Inmar Inc. at Rxrecalls@Inmar.com or call 855-745-9357 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