RECALL STOCK RESPONSE FORM

Product RECALL February 3rd, 2017
(Travoprost Ophthalmic Solution USP 0.004%)

VOLUNTARY RECALL TO THE RETAIL LEVEL

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.

Returned by _____DEA #_____

DEA Registration # is required, if not provided the processing of your form will be delayed.

Address_____

City_____ State_____ Zip_____

Contact Name (please print)_____Telephone #_____

Contact Signature _____Date_____

I have checked my stock and:

_____Do not have any stock of the recalled **items**.

OR

Have quarantined and listed in the box below the qty of recalled units 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 _____.

Item Description	NDC	Lot	Exp.	Qty returning
Travoprost Ophthalmic Solution USP 0.004% 2.5 mL Bottles	49884-044-48	G40814	09/2016	
		GA50089	12/2016	
		GA50259	01/2017	
		GA50657	03/2017	
		GA51073	06/2017	
		GA51651	09/2017	
		GA51652	09/2017	
		GA51722	09/2017	
		GA51723	09/2017	
		GA51760	10/2017	
		GA51761	10/2017	

Item Description	NDC	Lot	Exp.	Qty returning
Travoprost Ophthalmic Solution USP 0.004% 5 mL Bottles	49884-044-63	GA45033	10/2016	
		GA50258	01/2017	
		GA50944	05/2017	
		GA50174	06/2017	
		GA51340	07/2017	
		GA51479	08/2017	
		GA51762	10/2017	

In addition, please check the appropriate response below:

_____We **HAVE** received complaints of adverse events associated with use of the product.

_____We **HAVE NOT** received complaints of adverse events associated with use of the product.

If you did not purchase the product directly from the Manufacturer please complete the below section.

Purchased From: Wholesaler Name _____ DEA #_____

City_____ State_____

If you have any questions regarding this form or product return please contact Inmar at 1-800-967-5952, prompt # 1 for recall. Office hours: 9am to 5pm EST Mon thru Fri.

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