



URGENT: DRUG RECALL – RESPONSE FORM

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

or Email to: rxrecalls@inmar.com

Product Name	Package Description	Lot Number	NDC Number	Expiration Date
Pantoprazole Sodium for Delayed-Release Oral Suspension*, 40mg	30 Sachet	MHC1317A	62756-071-64	07/2023

Please check ALL appropriate boxes.

- I have read and understand the recall instructions provided in the 07/25/2022 letter.
- I have checked our stock and have quarantined inventory consisting of _____ units (number of full cartons) or _____ prescription packs (partial cartons).
- 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 wholesale 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 or call 1-855-898-9825.



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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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