



Camber Pharmaceuticals, Inc.
800 Centennial Ave., Suite 1
Piscataway, NJ 08854
Tel: 732-529-0430

September 30, 2025

Re: Recall Return Response Form

Product Name: Ketorolac Tromethamine Injection, USP 60 mg/2 mL (30 mg/mL)

Package Size: 1 x 25 x 2 mL (25's)

NDC: 31722-307-25 (Carton)
31722-307-02 (Vial Label)

Batch No's: AS1240347A, AS1240144A, AS1240145A, AS1240146A and AS1250295A

Please check all appropriate boxes:

- I have read and understand the recall instructions provided in the letter dated September 30, 2025.
- I have checked my stock and have quarantined inventory consisting of _____ vials.

Indicate disposition of recalled product:

- Returned (Specify Quantity _____ Vials, Date _____, and Method _____)
- Held for Return (Specify Quantity _____ Vials)
- Destroyed (Specify Quantity _____ Vials, Date _____, and Method _____)

Customer notification:

- I have identified and notified my customers who were shipped or may have been shipped this product by (Specify Date _____, and Method of Notification _____), or
- Attached is a list of customers who received / may have received this product. Please notify my customers.

Any reported adverse events associated with recalled product? Yes No

If yes, please explain: _____

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"/> Repacker |
| <input type="checkbox"/> Manufacturer | <input type="checkbox"/> Pharmacy - Retail |
| <input type="checkbox"/> Hospital Pharmacies | <input type="checkbox"/> Medical Laboratory |
| <input type="checkbox"/> Hospital/ Medical Facility | |

Other: _____

Name: _____

Title: _____

Telephone Number: () _____

Firm Name: _____

Street Address: _____

City / State / Zip: _____

DEA Number: _____

Debit Memo Number (if known) _____

Credit through: Wholesaler Name: _____

Wholesaler DEA Number _____

PLEASE FAX COMPLETED RESPONSE TO: ATTN: Recall Coordinator - FAX Number 817-868-5362 or

EMAIL TO: rxrecalls@inmar.com. or

MAIL TO:

Inmar

One West Fourth Street, Suite 500

Winston-Salem, North Carolina 27101

Telephone 855-898-4096