

URGENT: RECALL RETURN RESPONSE FORM

Product Name: Cinacalcet Tablets, 30 mg

Product Name	NDC #	Lot#	Expiry Date
Cinacalcet Tablets 30 mg, 30 count bottle	64380-883-04	7717825A	November 2028

Please check ALL appropriate boxes. (All sections must be completed)

- ☐ I have read and understand the recall instructions provided in the recall notification letter dated October 07, 2025. I further understand that this recall is to be carried out to the Retail Level and that it is my company's responsibility as a distributor/wholesaler to contact my customers at the Retail Level to request return of recall product.

Any adverse events received associated with recalled product? ☐ Yes ☐ No

If yes, please explain: _____ [Attach additional sheets if needed]

Please email / mail or fax your completed form to Inmar at rxrecalls@inmar.com or fax 817-868-5362. Mail to: Recall Coordinator, One West Fourth Street, Suite #500, Winston Salem, NC 27101

Customer information:

Company DEA: _____
Company Name: _____
Company Address: _____
Company City: _____ State: _____ Zip: _____
Form Completed by: _____ Title: _____
(Print Name)
Signature: _____ Date: _____
Email: _____

If you did not purchase directly from Strides Pharma please complete the below

Company you purchased product from (Wholesaler): _____
Wholesaler City/ State _____ Wholesaler DEA# _____
Form Completed by: _____ Title: _____
Signature: _____ Date: _____
Email: _____ Phone: _____

I have checked my stock for the recalled lot listed above < YES> or <NO> (Must circle one)

I have identified and notified my sub-accounts (retailers/pharmacies) that were shipped or may have been shipped affected recalled product < YES> or <NO> (Must circle one)

Do you have inventory of the recalled product from the lot number listed above < YES> or <NO> (Must circle one)

Please list inventory in your possession to be returned:

Lot #	Sealed Bottles Bottles count	Unsealed / Partial Bottles	
		Bottle count	Tablets count
7717825A			