ALVOGEN

URGENT: DRUG RECALL

RESPONSE FORM for Wholesalers/Retailers to Complete

Fentanyl Transdermal System, 25mcg/hr, 5 Pouches/Carton

Consumer Level - CII

02/05/2025*

1. **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 Alvogen Inc.:

Wholesaler Name:	DEA#:	
City:	State:	Zip:

I have checked my stock and:

☐ I confirm that all locations that received the impacted product have been notified to the consumer 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 these units 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 Total Number of Cartons to Return	Input Total Number of Pouches to Return
Fentanyl Transdermal System, 25mcg/hr	Carton (5 pouches/ Carton) Pouch (1 patch/pouch)	47781-424-47 47781-424-11	108319	04/2027		

If you have any questions regarding this form or product return please contact Inmar at 877-560-8457 (office hours 9am to 5pm EST Monday through Friday).

***Revised to correct issuance date**

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

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