RECALL RETURN RESPONSE FORM
AZELAIC ACID GEL, 15%- 50 g
(NDC 68462-626-52)
Retail Level
07/22/2024

Please fill out this form completely. By doing so, this will acknowledge that you have read and understood 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 Glenmark Pharmaceuticals Inc.:

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

I have checked my stock and communicated to my customers at the appropriate level:

□ I confirm that all locations that received the impacted products have been notified to the Retail 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 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. Date	Total Full/Sealed and Open Tube Count
AZELAIC ACID GEL 15%	68462-626-52	19241453	March - 2026	

If you have any questions regarding this form or product return please contact Inmar at 877-893-6105
Office hours 9am to 5pm EST Mon thru Fri.

Please fax this form to: 1-817-868-5362 or E-mail rxrecalls@inmar.com
Recall Event ID N131200 / RCL203-2024