



STOCK RESPONSE FORM

Recall of Diclofenac Sodium Solution USP, 2% Retail Level (06/22/2023)

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 # _____

Contact Signature _____ Date _____

I have checked my stock and:

_____ Do not have any stock of the **recalled product**.

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 #	Qty returning
DICLOFENAC SODIUM TOPICAL SOLUTION USP, 2%	62332-0487-12	220151	
DICLOFENAC SODIUM TOPICAL SOLUTION USP, 2%	62332-0487-12	220152	
DICLOFENAC SODIUM TOPICAL SOLUTION USP, 2%	62332-0487-12	220153	

If you did not purchase the product directly from the Manufacturer, please complete the below section.

Purchased From: Wholesaler Name _____ DEA # _____

City _____ State _____

If you have any questions regarding this form or product return please contact Inmar at 1-877-651-5403. Office hours 9am to 5pm EST Mon thru Fri.

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