

PRODUCT RECALL RESPONSE FORM

RCL212-25 / N131353

Everolimus tablet, 2.5mg, NDC 49884-119-91, ANDA 207934 28-count carton presentation**Everolimus tablet, 5mg, NDC 49884-125-91, ANDA 207934 28-count carton presentation****Everolimus tablet, 7.5mg, NDC 49884-127-91, ANDA 207934 28-count carton presentation****Everolimus tablet, 10mg, NDC 49884-128-91, ANDA 207934 28-count carton presentation**

Presentation	NDC	Lot	Date of Expiry	Units to returned
Everolimus 2.5mg tablets	49884-119-91	550172201	Jan-26	
Everolimus 2.5mg tablets	49884-119-91	550184801	Mar-26	
Everolimus 2.5mg tablets	49884-119-91	550204001	Jul-26	
Everolimus 5mg tablets	49884-125-91	550172301	Jan-26	
Everolimus 5mg tablets	49884-125-91	550184901	Mar-26	
Everolimus 5mg tablets	49884-125-91	550185001	Mar-26	
Everolimus 5mg tablets	49884-125-91	550189901	Apr-26	
Everolimus 5mg tablets	49884-125-91	550190001	Apr-26	
Everolimus 5mg tablets	49884-125-91	550203901	Jul-26	
Everolimus 5mg tablets	49884-125-91	550205601	Jul-26	
Everolimus 7.5mg tablets	49884-127-91	550167301	Nov-25	
Everolimus 7.5mg tablets	49884-127-91	550167401	Nov-25	
Everolimus 7.5mg tablets	49884-127-91	550185101	Mar-26	
Everolimus 7.5mg tablets	49884-127-91	550205701	Jul-26	
Everolimus 10mg tablets	49884-128-91	550162801	Nov-25	
Everolimus 10mg tablets	49884-128-91	550169801	Jan-26	

Please check ALL appropriate boxes:

- I have read and understand the instructions provided in the Product Recall Letter.
- I have checked and I do not possess any quantity of
- I have checked and I do possess a quantities of the above lots as indicated in the above table
 - I have listed in the box above the quantity of units currently available for returned.
 - Upon Inmar receipt of this Product Recall Response Form, Inmar will issue Return Authorization Labels. Please indicate the number of labels needed: _____
 - Any Adverse events associated with this product Yes No

If yes, please explain: _____

Please fill out this section completely (Where Applicable):

Contact Name _____ Title _____

Telephone Number _____

Firm Name _____

DEA Number _____ Address _____

DEA # is required, if it is not provided the processing of your form will be delayed.

City _____ State _____ Zip _____

Contact Signature _____ Date _____

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

If you have any questions regarding this form or product return please contact Inmar at 877-842-3418 Hours: Monday through Friday 9am to 5pm EST.