

Budesonide Inhalation Suspension 1mg/2ml
URGENT: DRUG RECALL – RESPONSE FORM
Retail Level
5/29/2026



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#:
<i>DEA # is required, if it is not provided, the processing of your form will be delayed.</i>	

Address:

City:	State:	Zip:
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Contact Name (Please Print):	
Telephone#:	Email:
Contact Signature:	Date:

DEBIT MEMO# (If unsure, leave blank):

Wholesaler Information if not directly purchased from Sun Pharma:

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 _____.

Product Name	Package Description	NDC#	Lot#	Expiration Date	Input Product to return
Budesonide Inhalation Suspension 1mg/2ml	30 ct	47335-633-49	BAG0074A	1/31/2027	

If you have any questions regarding this form or product return please contact Inmar at Rxrecalls@Inmar.com or call **855-800-0487** Office hours 9am to 5pm EST Monday through Friday.

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