WILSHIRE PHARMACEUTICALS, INC

RECALL RESPONSE FORM

A Voluntary Firm-Initiated Drug Recall was initiated by Wilshire Pharmaceuticals, LLC on February 4, 2021.

PRODUCT	NDC NUMBER	LOT NUMBER	EXPIRATION DATE
Meclizine HCl Tablets, USP 12.5 mg	52536-129-01	18030318	03/2021
Meclizine HCl Tablets, USP 25 mg	52536-133-01	18030329 18030330 18030331	03/2021

Reason for recall: Out of Specification (OOS) result of the Dissolution assay.

IMPORTANT! **Please provide your current contact information:**

Company Name:	
Contact Person:	
Mailing Address:	
Email Address:	
Phone & FAX:	

COMPLETE ALL BOXES THAT APPLY

1. ☐ I have read and understood the recall instructions provided in the Recall Letter dated February 4, 2021.
2. ☐ I have NONE of the recalled product in stock.
3. ☐ I have checked my inventory and have quarantined product in the amount listed in table below.

Please complete the table below

Lot Number	Expiry Date	Quantity to be Returned
18030318	03/2021	
18030329	03/2021	
18030330	03/2021	
18030331	03/2021	

4. ☐ **Yes** ☐ **No** Have you received any adverse events associated with the recalled product?
If yes, please explain: _____

5. Please check the appropriate box(es) to describe the nature of your business:

☐ Wholesaler/Distributor
☐ Food Service/Restaurant
☐ Grocery Corporate Headquarters
☐ Manufacturer
☐ Re-Packer
☐ Hospital/Medical Facility
☐ Pharmacy-Retail
☐ Medical Laboratory
☐ Hospital Pharmacies
☐ Retailer
☐ Other:_____

6. Return (email or FAX) this completed form as soon as possible to:
FAX: 817-868-5362.
Email address: rxrecalls@inmar.com

7. Completed By:

Name (Print): _____

Signature: _____

Title: _____