

## EXPANDED RECALL STOCK RETURN RESPONSE FORM

### Wholesale/Distributor & Retail Pharmacy Level Recall Only – May 13, 2026

Please complete and return this form immediately by FAX 1-817-868-5362 or email to [HikmaEvent@inmar.com](mailto:HikmaEvent@inmar.com).

**Please check ALL appropriate boxes:**

- ☐ I have read and understand the instructions provided in the enclosed **Alendronate Sodium Oral Solution, 70 mg/75 mL** recall packet.
- ☐ I **have** checked my stock of the recalled product listed below and have quarantined inventory and will be returning the number of units shown below. Upon receipt of this Recall Stock Return Response Form, **Inmar Rx Solutions, Inc.**, will issue return authorization shipping label(s) and a return kit. Please indicate the number of needed box labels \_\_\_\_\_.
- ☐ I **do not have** any stock of the below recalled product and will not be making a return.
- ☐ I **have** informed all my customers of the Retail Level Recall.

**Recalled Product: Alendronate Sodium Oral Solution, 70 mg/75 mL**

| Lot No. | Exp. Date | Product Packaging                | NDC No.      | Ship Dates               | Total Full Units (sealed) | Total Partial Units (opened) |
|---------|-----------|----------------------------------|--------------|--------------------------|---------------------------|------------------------------|
| AC2040A | 04/2026   | 4 x 75 mL<br>Single Dose Bottles | 0054-0282-59 | 09/09/2024 to 04/04/2025 |                           |                              |

Company Name: \_\_\_\_\_ DEA# \_\_\_\_\_  
*\*DEA # is required, if not provided the processing of your form may be delayed.*

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Contact Name: (please print) \_\_\_\_\_

Contact Name Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If you did not purchase the product directly from Hikma Pharmaceuticals USA Inc. (Formerly West-Ward Pharmaceuticals Corp.) please complete the below section:**

Purchased From: Wholesaler Name \_\_\_\_\_ DEA # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

- If you have any questions regarding this form or product return please contact **Inmar Rx Solutions, Inc.** at 1-877-411-4290 during office hours from 9:00am to 5:00pm EST, Monday through Friday.
- Please send this form to **Inmar Rx Solutions, Inc.** by FAX: 1-817-868-5362 or E-mail: [HikmaEvent@inmar.com](mailto:HikmaEvent@inmar.com).