

Somerset Therapeutics LLC
URGENT: DRUG RECALL – RESPONSE FORM
Dexamethasone Sodium Phosphate Injection USP 100mg/10mL
Retail Level
03/26/2026



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:
Contact Name (Please Print):		
Telephone#:	Email:	
Contact Signature:	Date:	
DEBIT MEMO# (If unsure, leave blank):		

Wholesaler Information if not directly purchased from Somerset Therapeutics LLC:

Wholesaler Name:	DEA#:
City:	State: Zip:

I have checked my stock and:

- 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	Total Quantity of Units (full and partial cartons)
Dexamethasone Sodium Phosphate Injection, USP 100mg/10mL (10mg/mL)	10 vials in 1 carton	70069-025-10	A240421	07/2026	

If you have any questions regarding this form or product return please contact Inmar at 877-871-1150 (office hours 9am to 5pm EST Monday through Friday).

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

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