



## **URGENT: DRUG RECALL – RESPONSE FORM**

**Please Complete This Form and Fax to: 817-868-5362**

**or Email to: [rxrecalls@inmar.com](mailto:rxrecalls@inmar.com)**

Product Name	Package Description	Lot Number	NDC Number	Expiration Date
Chlorthalidone Tablets, USP, 25 mg	100 Count	P0602	57664-648-88	03/2023

**Please check ALL appropriate boxes.**

☐ I have read and understand the recall instructions provided in the February 7, 2022 letter.

☐ I have checked our stock and have quarantined inventory consisting of \_\_\_\_\_ units (number of full cartons) or \_\_\_\_\_ prescription packs (partial cartons).

☐ Indicate disposition of recalled product:

☐ returned (**specify quantity, date and method**)/held for return;

Number of Labels Required for Return to Inmar: \_\_\_\_\_

☐ previously destroyed (**specify quantity, date and method**);

☐ I have identified and notified my retail customers that were shipped or may have been shipped this product by (**specify date and method of notification**); or

☐ Attached is a list of retail customers who received/may have received this product. Please notify my customers.

Any adverse events associated with recalled product? ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_

For return of affected product, please email [rxrecalls@inmar.com](mailto:rxrecalls@inmar.com) or call 1-855-869-9908.



## **URGENT: DRUG RECALL – RESPONSE FORM**

**Please Complete This Form and Fax to: 817-868-5362**

**or Email to: [rxrecalls@inmar.com](mailto:rxrecalls@inmar.com)**

Product Name	Package Description	Lot Number	NDC Number	Expiration Date
Chlorthalidone Tablets, USP, 25 mg	100 Count	P0602	57664-648-88	03/2023

Please check the appropriate box(es) to describe your business

- |   |  |
|---|--|
| <input type="checkbox"/> wholesaler/distributor         | <input type="checkbox"/> retailer                  |
| <input type="checkbox"/> grocery corporate headquarters | <input type="checkbox"/> hospital pharmacies       |
| <input type="checkbox"/> repacker                       | <input type="checkbox"/> hospital/medical facility |
| <input type="checkbox"/> pharmacy                       | <input type="checkbox"/> Other:                    |

Customer Name: \_\_\_\_\_ Title: \_\_\_\_\_

Company: \_\_\_\_\_ DEA Number: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Customer Debit Memo Number: \_\_\_\_\_

Wholesaler: \_\_\_\_\_ City\State: \_\_\_\_\_

Wholesaler DEA Number: \_\_\_\_\_

For return of affected product, please email [rxrecalls@inmar.com](mailto:rxrecalls@inmar.com) or call 1-855-869-9908.