URGENT: DRUG RECALL – RESPONSE FORM

Please Complete This Form and Fax to: 817-868-5362
or Email to: rxrecalls@inmar.com

Please check ALL appropriate boxes.

□ I have read and understand the recall instructions provided in the January 16, 2024 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 or call 1-877-813-7402.

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Product Name	Package Description	Lot Number	NDC Number	Expiration Date	Total Number of Units (number of full cartons) or prescription packs (partial cartons)
Mesalamine Delayed-Release Tablets, USP 1.2 gm	120 count	DNE0875A	63304-175-13	01/2025	
Mesalamine Delayed-Release Tablets, USP 1.2 gm	120 count	DNE0876A	63304-175-13	02/2025	
Mesalamine Delayed-Release Tablets, USP 1.2 gm	120 count	DNE0877A	63304-175-13	02/2025	
Mesalamine Delayed-Release Tablets, USP 1.2 gm	120 count	DNE1080A	63304-175-13	02/2025	
Mesalamine Delayed-Release Tablets, USP 1.2 gm	120 count	DNE1081A	63304-175-13	02/2025	
Mesalamine Delayed-Release Tablets, USP 1.2 gm	120 count	DNE1147A	63304-175-13	03/2025	
Mesalamine Delayed-Release Tablets, USP 1.2 gm	120 count	DNE1148A	63304-175-13	03/2025	

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

- □ wholesaler/distributor
- □ grocery corporate headquarters
- □ repacker
- □ pharmacy
- □ retailer
- □ hospital pharmacies
- □ hospital/medical facility
- □ Other:

Customer Name: _____ Title: _____

Company: _____ DEA Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Customer Email Address: _____

Customer Debit Memo Number: _____

Wholesaler: _____ City\State: _____

Wholesaler DEA Number: _____

Event ID: RCL006-2024 / N131126