



**RECALL RETURN RESPONSE FORM**  
Product Recall Verification/Response Form  
**Lacosamide Oral Solution, USP 10mg/mL**

**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 \_\_\_\_\_

**Please check the appropriate box ( cs) to describe your business**

☐ wholesaler/ distributor    ☐ retailer    ☐ grocery corporate headquarters    ☐ Repackcer  
☐ hospital pharmacies    ☐ manufacturer    ☐ pharmacy –retail    ☐ hospital pharmacies  
☐ medical laboratory    ☐ Hospital/ medical facility    ☐ Others: \_\_\_\_\_

DEA # \_\_\_\_\_

*\*DEA # is required, if it is not provided, the processing of your form will be delayed.*

Address \_\_\_\_\_

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

Contact Name (please print) \_\_\_\_\_ Telephone # \_\_\_\_\_

Contact Signature \_\_\_\_\_ Date \_\_\_\_\_

**I have checked my stock and:**

\_\_\_\_\_ Do not have any stock of the recalled **items**.

**OR**

I have quarantined and listed in the box below the quantity of recall 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 Description	NDC Number	Lot Numbers	Expiry Dates	QTY Returning (in bottles)
Lacosamide Oral Solution, USP 10mg/mL	31722-627-26	E222199	05/2024	
		E222200	05/2024	
		E222228	06/2024	

**If you did not purchase the product directly from the Manufacturer, please complete the below section.**

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

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

If you have any questions regarding this form or product return, please contact Inmar at 1-877-538-8447 prompt number 1 for recall. Office hours 9am to 5pm EST Mon thru Fri.

**Please fax this form to: 1-817-868-5362 or E-mail: [rxrecalls@inmar.com](mailto:rxrecalls@inmar.com)**