Glenmark Pharmaceuticals Inc.

RECALL RETURN RESPONSE FORM

INDOMETHACIN EXTENDED RELEASE CAPSULES USP 75 mg;
NDC 68462-325-60 (60's Container) NDC 68462-325-90 (90's Container)

Retail Level

07/31/2024

Please fill out this form completely. By doing so, this will acknowledge that you have read and understood the recall instructions and have taken the appropriate action.

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

Wholesaler Information if not directly purchased from Glenmark Pharmaceuticals Inc.:

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

I have checked my stock and communicated to my customers at the appropriate level:

☐ 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_____

Sr. No	Item Description	NDC	Lot#/ Pack Size	Expiry Date	Total Full/Sealed and Partial/Open Bottle Count
1	INDOMETHACIN ER CAP 75MG	68462-325-60	17240105/ 60's pack container	Dec-25	
2	INDOMETHACIN ER CAP 75MG	68462-325-90	17240105/ 90's pack container	Dec-25	

If you have any questions regarding this form or product return please contact Inmar at **877-861-8977**
Office hours 9am to 5pm EST Mon thru Fri.

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

Recall Event ID RCL207-24 / N131203