

Padagis
URGENT: DRUG RECALL – RESPONSE FORM
RX NYSTATIN CRM 100,000U/G 15G
Retail Level
6/18/2026



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#: _____
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 Padagis:

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 bottles/cartons)
Nystatin Cream 15 g	15 g cream / tube	45802-0059-35	205060	09/30/2027	

If you have any questions regarding this form or product return please contact Inmar at 855-937-2931 (office hours 9am to 5pm EST Monday through Friday).

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

Event ID: RCL164-26 / N131494