

Lupin Pharmaceuticals, Inc.**RECALL****Lisinopril and Hydrochlorothiazide Tablets USP 20mg/12.5mg****Wholesale Level****6/18/2025**

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 Lupin:

Wholesaler Name:

DEA#:

City:

State:

Zip:

I have checked my stock and communicated to my customers at the appropriate level:☐ 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	NDC#	Lot#	Expiration Date	Total Full Bottles/100 Tablets	Total Partial Bottles/Tablet Count
Lisinopril and Hydrochlorothiazide Tablets USP 20mg/12.5mg	68180-519-01	QA01081	4/30/2027		

If you have any questions regarding this form or product return please contact Inmar at 855-299-2509
Office hours 9am to 5pm EST Mon thru Fri.

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