SANDOZ A Novartis Division

RECALL STOCK RESPONSE FORM

RECALL of AZITHROMYCIN 250MG
(Retail Level)
(07/2018)

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 #_____

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 _____.

Item Description	NDC	Lot #	Qty returning
AZITHROMYCIN 250 MG	0781-5776-69	GZ0406	
AZITHROMYCIN 250 MG	0781-5776-69	HS2360	

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 1-800-967-5952. Office hours 9am to 5pm EST Mon thru Fri.

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

SANDOZ A Novartis Division

RECALL STOCK RESPONSE FORM

RECALL of Donepezil HCl ODT 5mg
(Retail Level)
(07/02/2018)

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 #_____

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 _____.

Item Description	NDC	Lot #	Qty returning
Donepezil HCl ODT 5mg	00781-5276-64	GV5947	
	00781-5276-64	HP4273	
	00781-5276-64	HP7999	
Donepezil HCl ODT 10mg	00781-5277-64	GT9329	
	00781-5277-64	GT9335	
	00781-5277-64	GU5010	
	00781-5277-64	GV8274	
	00781-5277-64	HG1597	
	00781-5277-64	HG1602	
	00781-5277-64	HG1605	
	00781-5277-64	HG1606	
	00781-5277-64	HG1608	
	00781-5277-64	HP4290	
	00781-5277-64	HG1611	
	00781-5277-64	HP4291	

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

Purchased From: Wholesaler Name _____DEA #_____

City_____ State_____

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SANDOZ A Novartis Division

RECALL STOCK RESPONSE FORM

RECALL of Haloperidol Tablets 0.5mg/1mg/2mg/5mg/10mg
(Retail Level)
(07/2018)

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 #_____

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 _____.

Item Description	NDC	Lot #	Qty returning
Haloperidol Tablets, 0.5mg	00781-1391-13	GX3374	
Haloperidol Tablets, 0.5mg	00781-1391-13	GX3375	
Haloperidol Tablets, 1mg	00781-1392-13	GR5658	
Haloperidol Tablets, 1mg	00781-1392-13	GY0724	
Haloperidol Tablets, 2mg	00781-1393-13	GU9925	
Haloperidol Tablets, 2mg	00781-1393-13	GY9223	
Haloperidol Tablets, 5mg	00781-1396-13	GN2013	
Haloperidol Tablets, 5mg	00781-1396-13	GN2014	
Haloperidol Tablets, 5mg	00781-1396-13	GN2015	
Haloperidol Tablets, 5mg	00781-1396-13	GR5643	
Haloperidol Tablets, 5mg	00781-1396-13	GR5656	
Haloperidol Tablets, 5mg	00781-1396-13	GR5657	
Haloperidol Tablets, 5mg	00781-1396-13	GV8400	
Haloperidol Tablets, 5mg	00781-1396-13	GX1357	
Haloperidol Tablets, 5mg	00781-1396-13	GX3376	
Haloperidol Tablets, 5mg	00781-1396-13	GY0712	
Haloperidol Tablets, 10mg	00781-1397-13	GK4734	
Haloperidol Tablets, 10mg	00781-1397-13	GX1356	

SANDOZ A Novartis Division

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

Purchased From: Wholesaler Name _____DEA #_____

City_____ State_____

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SANDOZ A Novartis Division

RECALL STOCK RESPONSE FORM

RECALL of Imipramine Tablets, 10x10 Blisters
(Retail Level)
(07/2018)

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 #_____

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 _____.

Item Description	NDC	Lot #	Qty returning
Imipramine Tablets, 10x10 Blisters	0781-1764-13	GW1756	
Imipramine Tablets, 10x10 Blisters	0781-1766-13	GP0032	

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 1-800-967-5952. Office hours 9am to 5pm EST Mon thru Fri.

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SANDOZ A Novartis Division

RECALL STOCK RESPONSE FORM

RECALL of Isosorbide Dinitrate (ISDN) 10mg/20mg
(Retail Level)
(07/2018)

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 #_____

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 _____.

Item Description	NDC	Lot #	Qty returning
Isosorbide Dinitrate (ISDN) 10mg	0781-1556-13	HD9905	
Isosorbide Dinitrate (ISDN) 10mg	0781-1556-13	HG6793	
Isosorbide Dinitrate (ISDN) 10mg	0781-1556-13	GU4390	
Isosorbide Dinitrate (ISDN) 20mg	0781-1695-13	GM5533	
Isosorbide Dinitrate (ISDN) 20mg	0781-1695-13	HA5303	

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 1-800-967-5952. Office hours 9am to 5pm EST Mon thru Fri.

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

SANDOZ A Novartis Division

RECALL STOCK RESPONSE FORM

RECALL of Naratriptan Orally Disintegrating Tablets 2.5mg
(Retail Level)
(07/02/2018)

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 #_____

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 _____.

Item Description	NDC	Lot #	Qty returning
Naratriptan Orally Disintegrating Tablets 2.5mg	0781-5527-37	GW3289	
Naratriptan Orally Disintegrating Tablets 2.5mg	0781-5527-37	GX9049	
Naratriptan Orally Disintegrating Tablets 2.5mg	0781-5527-37	HF2172	
Naratriptan Orally Disintegrating Tablets 2.5mg	0781-5527-37	HN7470	
Naratriptan Orally Disintegrating Tablets 2.5mg	0781-5527-37	HN7479	

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 1-800-967-5952. Office hours 9am to 5pm EST Mon thru Fri.

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

SANDOZ A Novartis Division

RECALL STOCK RESPONSE FORM

RECALL of Ondansetron Film Coated Tablets 8mg
(Retail Level)
(07/2018)

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 #_____

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 _____.

Item Description	NDC	Lot #	Qty returning
Ondansetron Film Coated Tablets 8mg	0781-1681-33	GR6331	
Ondansetron Film Coated Tablets 8mg	0781-1681-33	HC4804	

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

Purchased From: Wholesaler Name _____DEA #_____

City_____ State_____

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SANDOZ A Novartis Division

RECALL STOCK RESPONSE FORM

RECALL of Perphenazine Tablets 10x10 Blisters 2mg/4mg/8mg
(Retail Level)
(07/2018)

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 #_____

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 _____.

Item Description	NDC	Lot #	Qty returning
Perphenazine Tablets 10x10 Blitsters 2mg	0781-1046-13	GY9180	
Perphenazine Tablets 10x10 Blitsters 4mg	0781-1047-13	GT4308	
Perphenazine Tablets 10x10 Blitsters 4mg	0781-1047-13	GY9181	
Perphenazine Tablets 10x10 Blitsters 8mg	0781-1048-13	GZ0885	

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

Purchased From: Wholesaler Name _____DEA #_____

City_____ State_____

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