# RECALL STOCK RESPONSE FORM

## Hydroxyzine Hydrochloride Oral Solution, USP (Syrup), 10 mg/5 mL
### VOLUNTARY RECALL 12/10/20

**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 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 (please check all appropriate boxes):**

_____Do not have any stock of the recalled **items**.

_____I have identified and notified my customers that were shipped or may have been shipped this product.

_____I have quarantined and listed in the box below the quantity of recalled units 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 (Bottles) |
|---|---|---|---|
| Hydroxyzine Hydrochloride Oral Solution, USP (Syrup), 10 mg/5 mL | 60432-150-16 | UU1207 | |
| | 60432-150-16 | UU1326 | |
| | 60432-150-16 | UU1327 | |
| | 60432-150-04 | UU1328 | |

**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, Monday through Friday.

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