PRODUCT RECALL RESPONSE FORM

URGENT DRUG RECALL - CONSUMER LEVEL

Please complete the required information and fax to 1-817-868-5362 or email to rxrecalls@inmar.com
To the Attention of Drug Safety/ Recall Services - Viona Pharmaceuticals Inc.

Product Detail	NDC	Lot No.	Exp. Date	No. of Bottles Purchased	No of Bottles consumed	No. of Bottles in Possession	No of Bottles to be returned
Metformin Hydrochloride Extended-Release Tablets, USP 750 mg	72578-036-01	M008130	06/2022				
		M008131	06/2022				
		M008132	06/2022				
		M008133	06/2022				
		M010080	07/2022				
		M010081	07/2022				
		M011029	08/2022				
		M011030	08/2022				
		M011031	08/2022				
		M011032	08/2022				
		M011304	08/2022				
		M013394	09/2022				
		M013395	09/2022				
		M013396	09/2022				
		M013966	09/2022				

Product Detail	NDC	Lot No.	Exp. Date	No. of Bottles Purchased	No of Bottles consumed	No. of Bottles in Possession	No of Bottles to be returned
Metformin Hydrochloride Extended-Release Tablets, USP 750 mg	72578-036-01	M013967	09/2022				
		M100831	12/2022				
		M100832	12/2022				
		M100833	01/2023				
		M100834	01/2023				
		M101267	01/2023				
		M102718	01/2023				
		M102719	01/2023				

Please complete. Check ALL applicable.

____ I have read and understand the instructions provided in the recall letter and that this recall is being carried out to the **consumer level**.

____ I have checked my inventory and do not have the recalled product.

____ I have checked my inventory and have quarantined the product consisting of _____ bottles.

____ I would like to receive a pre-paid return label.

Total of Call Tags (Number of Boxes you will be returning): _____

Return product to:

Inmar Pharmaceuticals Services
3845 Grand Lakes Way,
Grand Prairie, Texas 75050

Note: A prepaid shipping label will be sent to the email address provided. The email will be coming from INMAR within 5 business days. Please check the spam folder if you do not see it in your inbox.

____ I have or will contact those further distributed to. This recall is to the consumer level.

Any adverse event associated with recalled product? ___ Yes ___ No

If yes, please explain:

_____

_____

Please check appropriate box to describe your business:

___ Wholesaler/Distributor	___ Pharmacy- Retail	___ Hospital/ Medical Facility
___ Retailers	___ Hospital Pharmacies	___ Medical Laboratory
___ Repackager	___ Manufacturer	___ Other: _____

* **Required fields must be completed in order to initiate call tag request.**

Contact Information:

*Name: _____

Title:_____*Tel Number:_____

*Email:_____

*Facility Name:_____

*Facility Address:_____

*City:_____ *State:_____ *Zip Code:_____

*Debit Memo_____

****Pharmacy/Hospital/Healthcare Provider required fields**

Wholesaler:_____ WholesalerAccount#:_____

** Pharmacy/Hospital/Medical Facility DEA # _____

Signature: _____ Date: _____

Please send this completed recall response form to: Email RXrecalls@inmar.com or Fax **1-817-868-5362**