APOTEX
Innovating for patient affordability

RECALL STOCK RESPONSE FORM

RECALL of Enoxaparin Sodium Injection, USP 100 mg/mL and 120 mg/0.8mL

(Consumer Level)
(02/02/2021)

Please fill out this form completely. By doing so, this will acknowledge that you have read and understood 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_____

Wholesaler Information if not directly purchased from Apotex:
Wholesaler Name: _____ Wholesaler DEA#: _____

Wholesaler City: _____ Wholesaler State: _____ Wholesaler Zip: _____

I have checked my stock and:

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

I confirm that all locations that have received the impacted products have been notified to the consumer level _____(Initial and date)

OR

I have quarantined and listed in the box(es) 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 required box labels _____.

I confirm that all locations that have received the impacted products have been notified to the consumer level _____(Initial and date)

Please see following table and indicate amount of product you have on hand in the appropriate column / row of the table.

Please return all pages together to avoid delays in return of product.

Product	Lot Number	Pack Size	Strength	NDC # on Carton	NDC # on Label	UPC # on Carton	UPC # on Label	Exp. Date (mm/yyyy)	Qty. of Full Cartons to return	Qty. of Partial Cartons to return
Enoxaparin Sodium Injection, USP	CS008	10 x 1mL Single Dose Syringes	100 mg/mL	60505-0795-4	60505-0795-1	360505079544	(01)10360505079510	04/2022		
	CT003	10 x 0.8mL Single Dose Syringes	120 mg/0.8mL	60505-0796-4	60505-0796-0	360505079643	(01)10360505079602	05/2022		

If you have any questions regarding this form or product return, please contact Inmar at 1-855-667-8717. Office hours 9am to 5pm EST Mon thru Fri.

Please return this form by fax to: 1-817-868-5362 or E-mail rxrecalls@inmar.com or by mail to Inmar, Attn: Recall Coordinator, Inmar, 635 Vine Street, Winston Salem, NC 27101