APOTEX
Innovating for patient affordability

RECALL STOCK RESPONSE FORM

Recall of Brimonidine Tartrate Ophthalmic Solution 0.15%

(Consumer Level)
(03/01/2023)

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: _____ Wholesale DEA #: _____

Wholesaler City: _____ Wholesaler State: _____ Wholesaler ZIP: _____

I/We, have checked our stock and confirm that:

☐ Do not have any stock of the recalled **lots**.

☐ 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 identified lots 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	Strength	Pack Size	NDC #	UPC Code on Carton	UPC Code on Bottle	Lot #	Expiry Date	Qty. of Full Bottles to return	Qty. of Partial Bottles to return
Brimonidine Tartrate Ophthalmic Solution	0.15%	5 mL	60505-0564-1	360505056415	(01)0(03)60505056415	TJ9848	02/2024		
						TJ9849			
						TK0258	04/2024		
						TK5341			
		10 mL	60505-0564-2	360505056422	(01)0(03)60505056422	TK0261			
		15 mL	60505-0564-3	360505056439	(01)0(03)60505056439	TK0262			

If you have any questions regarding this form or product return, please contact Inmar at 1-855-275-1273. 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, One West Fourth Street, Suite 500, Winston Salem, NC 27101