



## **URGENT: DRUG RECALL – RESPONSE FORM**

**Please Complete This Form and Fax to: 817-868-5362  
or Email to: [rxrecalls@inmar.com](mailto:rxrecalls@inmar.com)**

**Please check ALL appropriate boxes.**

- ☐ I have read and understand the recall instructions provided in the January 16, 2024 letter.
- ☐ I have checked our stock and have quarantined inventory consisting of \_\_\_\_\_ units (number of full cartons) or \_\_\_\_\_ prescription packs (partial cartons).
- ☐ Indicate disposition of recalled product:
  - ☐ returned (**specify quantity, date and method**)/held for return;  
Number of Labels Required for Return to Inmar: \_\_\_\_\_
  - ☐ previously destroyed (**specify quantity, date and method**);
- ☐ I have identified and notified my retail customers that were shipped or may have been shipped this product by (**specify date and method of notification**); or
  - ☐ Attached is a list of retail customers who received/may have received this product. Please notify my customers.

Any adverse events associated with recalled product? ☐ Yes ☐ No  
If yes, please explain: \_\_\_\_\_

For return of affected product, please email [rxrecalls@inmar.com](mailto:rxrecalls@inmar.com) or call 1-877-811-1320.

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<b>Product Name</b>	<b>Package Description</b>	<b>Lot Number</b>	<b>NDC Number</b>	<b>Expiration Date</b>	<b>Total Number of Units (number of full cartons) or prescription packs (partial cartons)</b>
Lurasidone Hydrochloride Tablets 60 mg	30 count	DNE0620A	47335-639-83	05/2025	
Lurasidone Hydrochloride Tablets 120 mg	30 count	DNE0621A	47335-579-83	11/2024	
Lurasidone Hydrochloride Tablets 120 mg	30 count	DNE0815A	47335-579-83	12/2024	

Please check the appropriate box(es) to describe your business

- |   |  |
|---|--|
| <input type="checkbox"/> wholesaler/distributor         | <input type="checkbox"/> retailer                  |
| <input type="checkbox"/> grocery corporate headquarters | <input type="checkbox"/> hospital pharmacies       |
| <input type="checkbox"/> repacker                       | <input type="checkbox"/> hospital/medical facility |
| <input type="checkbox"/> pharmacy                       | <input type="checkbox"/> Other:                    |

Customer Name: \_\_\_\_\_ Title: \_\_\_\_\_

Company: \_\_\_\_\_ DEA Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Customer Email Address: \_\_\_\_\_

Customer Debit Memo Number: \_\_\_\_\_

Wholesaler: \_\_\_\_\_ City\State: \_\_\_\_\_

Wholesaler DEA Number: \_\_\_\_\_

Event ID: RCL007-2024 / N131125