

RECALL STOCK RESPONSE FORM

Levofoxacin in 5% Dextrose Injection 750mg/150mL VOLUNTARY Recall 03/27/2018

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

I have checked my stock and:

_____ Do not have any stock of the recalled **items**.

OR

Have quarantined and listed in the box below the qty of withdrawn units I will be returning to Inmar, as soon as possible.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
Levofoxacin in 5% Dextrose Injection 750mg/150mL	55150-245-52	CLF160013	

If you did not purchase the product directly from the Manufacturer please complete the below section.

Purchased From: Wholesaler Name _____

City _____ State _____

Wholesaler DEA# _____

If you have any questions regarding this form or product return please contact Inmar at 1-800-967-5952. Office hours 9am to 5pm EST Mon - Fri.

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