



Recall Return Response Form

Cefixime Capsules 400 mg 50 count
Retail Level Recall

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

I have checked my stock and:

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

OR

I have quarantined and listed in the box 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 needed box labels _____.

Item Description	NDC	Lot #	Qty returning
Cefixime Capsules 400 mg	67877-584-50	20140282	

If you have any questions regarding this form or product return, please contact Inmar at 1 855.827.6898. Office hours 9am to 5pm EST Mon thru Fri.

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