

RECALL STOCK RESPONSE FORM

Prednisolone Sodium Phosphate Oral Solution, 15 mg/5 mL VOLUNTARY RECALL 09/23/19

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 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 (please check all appropriate boxes):

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

_____ I have identified and notified my customers that were shipped or may have been shipped this product.

_____ I have quarantined and listed in the box below the quantity of recalled 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 (Units of 237 ml)
Prednisolone Sodium Phosphate Oral Solution, 15 mg/5 mL	60432-212-08	US1450	
		US1570	
		UT1018	
		UT1173	
		UT1348	
		UT1354	

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

Purchased From: Wholesaler Name _____ DEA # _____

City _____ State _____

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

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