

## **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**