

RECALL RETURN RESPONSE FORM

Please Complete and Return this Form within 15 days of Receipt

Product	Pack Size	Strength	UPC Code on bottle	Lot #	Expiry Date	Sealed Quantity to be Returned	Open Quantity to be Returned
Prenatab Rx Tablets	90 count bottle	29-1 MG	60258-193-09	108758	08/2024		

Please check ALL appropriate boxes:

☐ I have read and understand the recall instructions provided in the 12JAN2022 letter.

☐ I have identified and notified my customers that were shipped or may have been shipped this product; **Identify Quantity, Date, and Method:** _____

Any adverse events associated with recalled product? ☐ Yes ☐ No

If yes, please explain: _____

I have checked my stock and:

☐ Do not have any stock of the recalled items.

☐ I have quarantined and listed in the above table the quantity of recall units I will be returning to Currax as soon as possible. Upon receipt of this Response Form, Currax will issue a Return Authorization to be included with the product.

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

Purchased From: Wholesaler Name _____

Wholesaler DEA# _____

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

☐ Wholesaler/ Distributor

☐ Retailer

☐ Grocery Corporate Headquarters

☐ Food service/ Restaurant

☐ Repacker

☐ Manufacturer

☐ Pharmacy - Retail

☐ Hospital/Medical Facility

☐ Hospital Pharmacies

☐ Medical Laboratory

☐ Other: _____

Contact Name/Title	
Contact Phone	
Contact Email	
Firm Name	
DEA #	
Address	
Address	
City/State/Zip	

PLEASE RETURN COMPLETED RESPONSE FORM TO:

Inmar, 635 Vine Street, Winston Salem, NC 27101

Email address: rxrecalls@inmar.com

FAX: 817-868-5362.