

RECALL STOCK RESPONSE FORM

Recall of Calcitonin Salmon (synthetic origin) Nasal Spray (Calcitonin Salmon Nasal Solution, USP)

(Retail / Pharmacy Level)
(04/26/2023)

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

Wholesaler Information if not directly purchased from Apotex:

Wholesaler Name: _____ Wholesale DEA #: _____

Wholesaler City: _____ Wholesaler State: _____ Wholesaler ZIP: _____

I/We, have checked our stock and confirm that:

- ☐ Do not have any stock of the recalled **lot**.
- ☐ I have quarantined and listed in the box(es) 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 required box labels ____.
- ☐ I confirm that all locations that have received the identified lot have been notified to the Retail / Pharmacy level _____.
(Initial and date)

Please see following table and indicate amount of product you have on hand in the appropriate column / row of the table.

Please return all pages together to avoid delays in return of product.

| Product | Strength | Pack Size | NDC # | UPC Code on Carton | Lot # | Expiry Date | Qty. of Full Bottles to return | Qty. of Partial Bottles to return |
|---|---|-----------|--------------|--------------------|--------|-------------|--------------------------------|-----------------------------------|
| Calcitonin Salmon (Synthetic Origin) Nasal Spray | 2200 USP Calcitonin Salmon Units/mL | 3.7 mL | 60505-0823-6 | 360505082360 | TH5645 | 01/2025 | | |

If you have any questions regarding this form or product return, please contact Inmar at 1-877-619-9475. Office hours 9am to 5pm EST Mon thru Fri.

Please return this form by fax to: 1-877-868-5362 or E-mail rxrecalls@inmar.com or by mail to Inmar, Attn: Recall Coordinator, Inmar, One West Fourth Street, Suite 500, Winston Salem, NC 27101

Event ID RCL086-23 / N130929