RECALL
Vasostrict®, 20 Units per 100mL
Hospital/Clinic Level
1/9/2024

Please fill out this form completely. By doing so, this will acknowledge that you have read and understand the withdrawal 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#:	Email:	
Contact Signature:	Date:	
DEBIT MEMO# (If unsure, leave blank):		

Wholesaler Information if not directly purchased from Par Pharmaceutical:

Wholesaler Name:	DEA#:	
City:	State:	Zip:

I have checked my stock and communicated to my customers at the appropriate level:

- I confirm that all locations that received the impacted products have been notified to the retail level _____(Initial and date)
- _____I do not have any stock of the recalled items. **OR**

  I have quarantined and listed in the box below the quantity of recalled 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#	Exp Date	Total Vial Count
Vasostrict® 20 Units per 100mL	42023-237-10 Cartons of 10 vials	66702	02/2025	

If you have any questions regarding this form or product return please contact Inmar at 1-877-773-9530. Office hours 9am to 5pm EST Mon thru Fri.

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