Lannett

RECALL STOCK RESPONSE FORM

RECALL of Levetiracetam Oral Solution, 100mg/mL
UPDATE – Consumer Level
12/06/2019

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 it is not provided, the processing of your form will be delayed.

Address_____

City_____ State_____ Zip_____

Contact Name (please print)_____ Telephone #_____

Contact Signature _____Date_____

☐ I have read and understand the recall instructions provided in the 06Dec2019 letter.

I have checked my stock and:

_____Do not have any stock of the recalled **items**.

OR

I have quarantined and listed in the box 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 needed box labels _____.

Item Description	NDC	Lot #	Expiration	Qty returning
Levetiracetam Oral Solution 100mg/mL	54838-548-80	2190A	07/2021	
Levetiracetam Oral Solution 100mg/mL	54838-548-80	2191A	07/2021	

Indicate disposition of recalled product:

☐ returned (specify quantity, date and method)/held for return;

☐ destroyed (specify quantity, date and method);

☐ quarantined pending correction (specify quantity);

Notification

☐ I have identified and notified my customers that were shipped or may have been shipped this product by (specify date and method of notification);

<or>

☐ Attached is a list of customers who received/may have received this product. Please notify my customers

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: _____

Name: _____

Title: _____

Tel. number: ( ) _____

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

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