



PRODUCT RECALL RESPONSE FORM
URGENT DRUG RECALL – RETAIL LEVEL

Please complete the required information and fax it to **1-817-868-5362**
or email to rxrecalls@inmar.com

To the Attention of Drug Safety/ Recall Services-Viona Pharmaceuticals Inc.

Product Detail	NDC Number	Lot No.	Exp Date	No. of Bottle Purchased	No of the Bottles consumed	No. of bottles in Possession	No of Bottles to be returned
Dapsone Gel 7.5%	72578-094-02	T400512	02/2026				

No. of Returns kit required: _____

Please mark as applicable

☐ We currently do not have any inventory of the above-listed Lot/bottles

☐ We are notifying our customers

☐ We have identified and notified my customers that were shipped or may have been shipped this product by _____;

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

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

If yes, please explain:

Viona Pharmaceuticals Inc.

20 Commerce Drive, Ste 340, Cranford, NJ 07016

Phone: +1 908 956 0600 *Fax: +1 908 514 4005 *www.vionausa.com



Please check appropriate box to describe your business

☐ Wholesaler/Distributor

☐ Retailers

☐ Repackager

☐ Manufacturer

☐ Pharmacy- Retail

☐ Hospital/ Medical Facility

☐ Hospital Pharmacies

☐ Medical Laboratory

☐ Other: _____

Name: _____

Title: _____

Tel Number: _____

Firm Name: _____

DEA# _____

Address: _____

City/ State: _____

If you have not purchased, the concerned lot directly from Viona Pharmaceuticals Inc., then
please provide details of your wholesaler: _____ (Name, City)

DEA# _____

Signature: _____

Date: _____

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