RECALL STOCK RESPONSE FORM
Wholesale Level Recall
Retail Level – Sub Recall
01/07/2025

Guaifenesin and Codeine Phosphate Oral Solution, USP, USP (100mg/10 mg per 5 ml)

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 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 #	Qty returning
Guaifenesin and Codeine Phosphate Oral Solution, USP, USP (100mg/10 mg per 5 ml)	0121-775-16	4B07	

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

Purchased From: Wholesaler Name _____DEA #_____

City_____ State_____

If you have any questions regarding this form or product return, please contact Inmar at 1-877-560-3273 Office hours 9am to 5pm EST Mon thru Fri.

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