

RECALL STOCK RESPONSE FORM

RECALL of Aspirin and Extended-release Dipyridamole Capsules, 25 mg/200 mg (Retail Level) (03/04/2019)

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 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
Aspirin and Extended-release Dipyridamole Capsules, 25 mg/200 mg, 20 count Unit Dose Blisters	Carton NDC#: 60687-305-32 (Individual Dose NDC: 60687-305-33)	174262	
Aspirin and Extended-release Dipyridamole Capsules, 25 mg/200 mg, 20 count Unit Dose Blisters	Carton NDC#: 60687-305-32 (Individual Dose NDC: 60687-305-33)	176469	
Aspirin and Extended-release Dipyridamole Capsules, 25 mg/200 mg, 20 count Unit Dose Blisters	Carton NDC#: 60687-305-32 (Individual Dose NDC: 60687-305-33)	177897	
Aspirin and Extended-release Dipyridamole Capsules, 25 mg/200 mg, 20 count Unit Dose Blisters	Carton NDC#: 60687-305-32 (Individual Dose NDC: 60687-305-33)	178318	
Aspirin and Extended-release Dipyridamole Capsules, 25 mg/200 mg, 20 count Unit Dose Blisters	Carton NDC#: 60687-305-32 (Individual Dose NDC: 60687-305-33)	178436	

Aspirin and Extended-release Dipyridamole Capsules, 25 mg/200 mg, 20 count Unit Dose Blisters	Carton NDC#: 60687-305-32 (Individual Dose NDC: 60687-305- 33)	179547	

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 1-800-967-5952. Office hours 9am to 5pm EST Mon thru Fri.

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