1400 Atwater Drive
Malvern, PA 19355

PRODUCT RECALL RESPONSE FORM

Clonazepam Orally Disintegrating Tablets, USP (C-IV)

The below lots are in scope of this recall

Lot #	Date of Expiry	Units to be returned
550176501	Feb 2027	
550174101	Jan 2027	
550142801	Aug 2026	
550142901	Aug 2026	
550143001	Aug 2026	
550143101	Aug 2026	
550143201	Aug 2026	
550143301	Aug 2026	
550143401	Aug 2026	
550147201	Aug 2026	
550147401	Aug 2026	
550145201	Aug 2026	
550175901	Feb 2027	
550176001	Feb 2027	
550176201	Feb 2027	
550176601	Feb 2027	

The potential product descriptions are:

Potential Product Description	NDC Number
Clonazepam Orally Disintegrating Tablets, USP (C-IV) 2mg	49884-310-02
Clonazepam Orally Disintegrating Tablets, USP (C-IV) 1 mg	49884-309-02
Clonazepam Orally Disintegrating Tablets, USP (C-IV) 0.125 mg	49884-306-02
Clonazepam Orally Disintegrating Tablets, USP (C-IV) 0.25 mg	49884-307-02

Please check ALL appropriate boxes:

□ I have read and understand the instructions provided in the Product Recall Letter.

□ I have checked and I do not possess any quantity of above lots as indicated in the above table

□ I have checked and I do possess a quantities of the above lots as indicated in the above table

- I have listed in the box above the quantity of units currently available for returned.
- Upon Inmar receipt of this Product Recall Response Form, Inmar will issue Return Authorization Labels. Please indicate the number of labels needed: _____
- Any Adverse events associated with this product Yes ☐ No ☐

  If yes, please explain: _____

Please fill out this section completely (Where Applicable):

Contact Name _____ Title _____

Telephone Number_____

Firm Name _____DEA Number _____

Address_____

DEA # is required, if it is not provided the processing of your form will be delayed.

City_____State_____Zip_____

Contact Signature_____Date_____

Non-Wholesaler customers (Retail Pharmacies) only: Please complete the following:

Wholesaler Name _____ DEA# _____

City:_____ State:_____

Please fax this form to: 1-817-868-5362 or E-mail to: rxrecalls@inmar.com
If you have any questions regarding this form or product return please contact Inmar at 855-589-1836 Hours: Monday through Friday 8am to 5pm EST.