hikma.
503B

Hikma Injectables USA Inc. d/b/a Hikma 503B

Recall Return Response Form – Hospital/Medical Center Level – 12/19/2024

KETAMINE HCL 50 MG PER ML INJECTION (Compounded Drug) and
PHENYLEPHRINE HCL 1 MG PER 10 ML IN 0.9% SODIUM CHLORIDE INJECTION (Compounded Drug)

Please complete and return this form immediately by FAX 1-817-868-5362 or email to HikmaEvent@inmar.com.

Please check ALL appropriate boxes:

☐ I have read and understand the instructions provided in the enclosed **ketamine HCl 50 mg per mL Injection and phenylephrine HCl 1 mg per 10mL in 0.9% Sodium Chloride Injection** at the **Hospital/Medical center level** recall packet.

☐ I **have** checked my stock of the recalled product listed below and have quarantined inventory and will be returning the number of units shown below. Upon receipt of this Return Response Form, Inmar Rx Solutions, Inc., will issue return authorization shipping label(s) and a return kit.

Please indicate the number of box labels needed: _____

☐ I **do not have** any stock of the below recalled product and will not be making a return.

Recalled Products: ketamine HCl 50 mg per mL Injection (Compounded Drug) and phenylephrine HCl 1 mg per 10mL in 0.9% Sodium Chloride Injection (Compounded Drug)

Lot No.	Product Name	Use By Date	Product Packaging	NDC No.	Ship Dates	Total Full unit cartons (sealed)	Total Partial Units (opened cartons)
242560008D	Ketamine HCl	2025/01/15	50mg/mL (50mg/mL), 1mL fill in 3mL syringe (25 syringes / shipper)	63037-137-25	11/06/2024 - 11/12/2024		
242970002D	Ketamine HCl	2025/02/25	50mg/mL (50mg/mL), 1mL fill in 3mL syringe (25 syringes / shipper)	63037-137-25	12/05/2024 - 12/06/2024		
243120003D	phenylephrine HCl in 0.9% Sodium Chloride Injection	2025/03/11	1 mg per 10 mL (100 mcg/mL), 10mL syringe (25 syringes / shipper)	63037-173-25	12/04/2024 only		

Company Name: _____ DEA#: _____

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

Address: _____ City: _____

State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Contact Name: _____ ***(please print)***

Contact Signature: _____ Date: _____

- If you have any questions regarding this form or product return, please contact **Inmar Rx Solutions, Inc.** at 877-535-3247 during office hours from 9:00am to 5:00pm EST, Monday through Friday.
- Please send this form to **Inmar Rx Solutions, Inc.** by FAX: 1-817-868-5362 or E-mail: HikmaEvent@inmar.com.
- Please include a copy in the box with your returns to ensure proper credit.

N131246