



RECALL STOCK RESPONSE FORM

RECALL of Atorvastatin Calcium Tablets (Retail Level) 05/30/2018

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.

Company Name _____ DEA # _____

Debit Memo # _____ Original Invoice # _____

**DEA # and Debit Memo # is required, without it, 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 recalled units I will be returning to Inmar. Upon receipt of this Response Form, Inmar, will issue return authorization label(s) and will need _____ # of box labels

Item Description	NDC	Lot	Quantity returned
Atorvastatin Calcium Tablets 80mg, 90 count	55111-124-90	T800064	

Wholesalers and Distributors only

☐ I have identified my customers that were shipped or may have been shipped this product. Attached is a list of customers with their contact details who received/may have received this product.

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) Monday through Friday.

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