

## **URGENT: DRUG RECALL – RESPONSE FORM**

**Please Complete This Form and Fax to: 817-868-5362**

**or Email to: [rxrecalls@inmar.com](mailto:rxrecalls@inmar.com)**

Product Name	Brand Name	Lot Number	UPC Number	NDC Number	Expiration Date
Loperamide HCL Tablets, USP, 2 mg (24 Caplets) “Anti Diarrheal”	N/A	2979325	0 93351 11270 6	53943-123-24	05/2021

**Please check ALL appropriate boxes.**

- ☐ I have read and understand the recall instructions provided in the December 26, 2018 letter.
- ☐ I have checked our stock and have quarantined inventory consisting of \_\_\_\_\_ units (number of full cartons) or \_\_\_\_\_ prescription packs (partial cartons).
- ☐ Indicate disposition of recalled product:

☐ returned (**specify quantity, date and method**)/held for return;

Number of Labels Required for Return to Inmar: \_\_\_\_\_

- ☐ previously destroyed (**specify quantity, date and method**);
- ☐ I have identified and notified my retail customers that were shipped or may have been shipped this product by (**specify date and method of notification**); or
- ☐ Attached is a list of retail customers who received/may have received this product. Please notify my customers.

Any adverse events associated with recalled product? ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_

For return of affected product, please email [rxrecalls@inmar.com](mailto:rxrecalls@inmar.com) or call 1-800-967-5952.



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Please check the appropriate box(es) to describe your business

- |   |  |
|---|--|
| <input type="checkbox"/> wholesaler/distributor         | <input type="checkbox"/> retailer                  |
| <input type="checkbox"/> grocery corporate headquarters | <input type="checkbox"/> hospital pharmacies       |
| <input type="checkbox"/> repacker                       | <input type="checkbox"/> hospital/medical facility |
| <input type="checkbox"/> pharmacy                       | <input type="checkbox"/> Other:                    |

Customer Name: \_\_\_\_\_ Title: \_\_\_\_\_

Company: \_\_\_\_\_ DEA Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Customer Debit Memo Number: \_\_\_\_\_

Wholesaler: \_\_\_\_\_ City\State: \_\_\_\_\_

Wholesaler DEA Number: \_\_\_\_\_

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