



## **RECALL RESPONSE FORM**

### **LISINAPRIL TABLETS, USP 40 mg VOLUNTARY RECALL – RETAIL LEVEL**

PRODUCT DESCRIPTION	NDC NUMBER	LOT #	EXP DATE	Units Returning
Lisinopril Tablets, USP 40mg, 500 count bottle	0603-4214-28	C0570215A	2/17	
Lisinopril Tablets, USP 40mg, 45 count bottle	0603-4214-60	C0570215B	2/17	

**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.

The affected product was distributed by Qualitest between April 15, 2015 and May 11, 2015.

Store Name \_\_\_\_\_ DEA # \_\_\_\_\_  
*\*DEA # is required, if not provided the processing of your form will be delayed.*

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact Name (please print) \_\_\_\_\_ Telephone # \_\_\_\_\_

Contact Signature \_\_\_\_\_ Date \_\_\_\_\_

**I have notified my customers that were sold/shipped affected recalled product**

Circle one: YES or NO-I did not sell/ship affected product.

**I have checked my stock and:**

\_\_\_\_\_ Do not have any stock of the recalled products listed above. **OR**

Have quarantined and listed in the box above the quantity of units the above product lots. I will be returning to CLS MedTurn, an Inmar company, as soon as possible. Upon receipt of this Response Form, CLS MedTurn, an Inmar company, will issue return authorization labels \_\_\_\_\_ (please indicate the # of box labels needed.)

**If you did not purchase the product directly from the Manufacturer please complete the below section.**

Purchased From: Name \_\_\_\_\_ DEA # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If you have any questions regarding this form or product return please contact  
CLS MedTurn, an Inmar company at 1-800-967-5952

**Please fax this form to: 1-817-868-5362 or E-mail at: [rxrecalls@inmar.com](mailto:rxrecalls@inmar.com)**