PATIENT RECALL RESPONSE FORM

Product RECALL 05/10/2016
ZOLPIDEM TARTRATE SUBLINGUAL TABLETS 1.75 mg & 3.5mg

VOLUNTARY RECALL

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.

Name _____

Address _____

City _____ State _____ Zip _____

Telephone # _____

Signature _____ Date _____

Upon receipt of this Response Form, Inmar, will issue a return authorization label

Product	NDC	Lot Number	Number of cartons returning
ZOLPIDEM TARTRATE SUBLINGUAL TABLETS 1.75 mg	43386-762-30	M16140A	
ZOLPIDEM TARTRATE SUBLINGUAL TABLETS 3.5 mg	43386-761-30	M16144A	

Please complete the below section.

Pharmacy Name _____

City _____ State _____

If you have any questions regarding this form or product return please contact Inmar at 1-800-967-5952 Office hours 8am to 5pm Mon thru Fri.

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